

2013

Provider Manual

Ohio



Your Extended Family.

2013 PROVIDER MANUAL

Molina Healthcare of Ohio, Inc.

**Molina Medicare Options Plus
(HMO Special Needs Plan)**

Thank you for your participation in the delivery of quality healthcare services to Molina Medicare Members. We look forward to working with you.

This Provider Manual shall serve as a supplement as referenced thereto and incorporated therein, to the Molina of Ohio Inc. Services Agreement. In the event of any conflict between this Manual and the Manual distributed with reference to Molina Medicaid Members, this Manual shall take precedence over matters concerning the management and care of Molina Medicare Members.

The information contained within this Manual is proprietary. The information is not to be copied in whole or in part; nor is the information to be distributed without the express written consent of Molina Medicare.

The Provider Manual is a reference tool that contains eligibility, benefits, contact information and policies/procedures for services that Molina Medicare specifically provides and administers on behalf of Molina Medicare health plans.



Dear Provider:

I would like to extend a personal welcome to Molina Medicare of Ohio. Enclosed is your Molina Medicare Provider Manual, written specifically to address the requirements of delivering healthcare services to Molina Medicare members.

This manual is designed to provide you with assistance in all areas of your practice, from making referrals to receiving payment for your services. In some cases, you may have developed internal procedures that meet the standards set out in this manual. In these instances you do not need to change your procedures as long as they adhere to the standards outlined in this manual.

From time to time, this manual will be revised as policies or regulatory requirements change. All changes and updates will be updated and posted to the Molina Medicare website as they occur. All contracted providers will receive an updated Provider Manual annually, which will be made available at www.MolinaMedicare.com.

Thank you for your active participation in the delivery of quality healthcare services to Molina Medicare members.

Sincerely,

Amy Schultz Clubbs
President
Molina Healthcare of Ohio, Inc.

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I. Introduction

Molina Medicare Options Plus (HMO SNP) is the brand name of Molina Healthcare of Ohio, Inc.'s Molina Medicare health plans.

Molina Medicare is licensed and approved by the Centers for Medicare & Medicaid Services (CMS) to operate in the following states: California, Florida, Illinois, Michigan, New Mexico, Ohio, Texas, Utah and Washington.

A. Molina Medicare Options Plus (HMO SNP) Special Needs Plan

Options Plus (HMO SNP) is the name of Molina's Special Needs Plan (HMO SNP), which provides Medicare Advantage and Prescription Drug Benefits. The Options Plus plan was designed for Members who are dual eligible: individuals who are eligible for both Medicare and Medicaid in order to provide quality healthcare coverage and service with little out-of-pocket costs. Options Plus (HMO SNP) embraces Molina's longstanding mission to serve those who are the most in need and traditionally have faced barriers to quality health care.

Please contact the Member Services Department Monday through Sunday from **8:00 a.m. – 8:00 p.m. toll free at (866) 472-4584** with questions regarding this program.

B. Use of this Manual

From time to time, this manual will be revised as policies or regulatory requirements change. All changes and updates will be updated and posted to the Molina Medicare website as they occur. All contracted providers will receive an updated Provider Manual annually, which will be made available at www.MolinaMedicare.com.

This manual contains samples of the forms needed to fulfill your obligations under your Molina contract. If you are already using forms that accomplish the same goals, you may not need to modify them.

II. Background and Overview of Molina Healthcare, Inc. (Molina)

Molina, headquartered in Long Beach, California, is a multi-state, managed care company focused on providing healthcare services to people who receive benefits through government-sponsored programs. Molina is a physician-led, family-founded health plan that believes each person should be treated like family ... and that each person deserves quality care.

C. David Molina, M.D., founded the company in 1980 as a provider organization with a network of primary care clinics in California. Included in Molina Provider networks are company-owned and operated primary care clinics, independent providers and medical groups, hospitals and ancillary providers.

As the need for more effective management and delivery of healthcare services to underserved populations continued to grow, Molina became licensed as a Health Maintenance Organization (HMO) in California. Today, Molina serves over 1.8 million members in 10 states.

In 2010, Molina Healthcare acquired Unisys' Health Information Management Division to form Molina Medical Solutions (MMS). This business unit provides design, development, implementation, and business process outsourcing solutions to state governments for their Medicaid Management Information Systems.

A. Molina's Mission, Vision and Core Values

- 1. Mission** – to promote health and provide health services to families and individuals who traditionally have faced barriers to quality health, have lower income and are covered by government programs.
- 2. Vision** – Molina is an innovative healthcare leader providing quality care and accessible services in an efficient and caring manner.
- 3. Core Values:**
 - We strive to be an exemplary organization;
 - We care about the people we serve and advocate on their behalf;
 - We provide quality service and remove barriers to health services;
 - We are healthcare innovators and embrace change quickly;
 - We respect each other and value ethical business practices; and
 - We are careful in the management of our financial resources and serve as prudent stewards of the public funds.

B. Significant Growth of Molina

Since 2001, Molina, a publicly traded company (NYSE: MOH), has achieved significant member growth through internal initiatives and acquisitions of other health plans. This strong financial and operational performance is uniquely attributable to the recognition and

understanding that members have distinct social and medical needs, and are characterized by their cultural, ethnic and linguistic diversity.

Since the company's inception thirty years ago, the focus has been to work with government agencies to serve low-income and special needs populations. Success has resulted from:

- Expertise in working with federal and state government agencies;
- Extensive experience in meeting the needs of members;
- Owning and operating primary care clinics;
- Cultural and linguistic expertise; and
- A focus on operational and administrative efficiency.

C. The Benefit of Experience

Beginning with primary care clinics in California, the company grew in the neighborhoods where members live and work. This early experience impressed upon management the critical importance of community-based patient education and greater access to the entire continuum of care, particularly at the times when it can do the greatest good.

Molina has focused exclusively on serving low-income families and individuals who receive healthcare benefits through government-sponsored programs and has developed strong relationships with members, providers and government agencies within each regional market that it serves. Molina's ability to deliver quality care, establish and maintain provider networks, and administer services efficiently has enabled it to compete successfully for government contracts.

D. Administrative Efficiency

Molina operates its business on a centralized platform that standardizes various functions and practices across all of its health plans in order to increase administrative efficiency. Each state licensed subsidiary contracts with Molina Healthcare, Inc. (MHI) for specific centralized management, marketing, and administrative services.

E. Quality

Molina is committed to quality and has made accreditation a strategic goal for each of Molina's health plans. Year after year, Molina health plans have received accreditation from the National Committee for Quality Assurance (NCQA). The NCQA accreditation process sets the industry standard for quality in health plan operations.

F. Flexible Care Delivery Systems

Molina has constructed its systems for healthcare delivery to be readily adaptable to different markets and changing conditions. Healthcare services are arranged through contracts with providers that include Molina-owned clinics, independent providers, medical groups,

hospitals and ancillary providers. Our systems support multiple contracting models, such as fee-for-service, capitation, per diem, case rates and diagnostic-related groups (DRGs).

G. Cultural and Linguistic Expertise

National census data shows that the United States' population is becoming increasingly diverse. Molina has a thirty-year history of developing targeted healthcare programs for a culturally diverse membership and is well-positioned to successfully serve these growing populations by:

- Contracting with a diverse network of community-oriented providers who have the capabilities to address the linguistic and cultural needs of members;
- Educating employees about the differing needs among Members; and
- Developing member education material in a variety of media and languages and ensure that the literacy level is appropriate for our target audience.

H. Member Marketing and Outreach

Member marketing creates an awareness of Molina as an option for Medicare-eligible beneficiaries including those who are dual eligible beneficiaries. Member marketing relies heavily on community outreach efforts primarily through community agencies serving the targeted population. Sales agents, brochures, billboards, physician partners, public relations and other methods are also used in accordance with the Centers for Medicare & Medicaid Services (CMS) marketing guidelines.

III. Contact Information for Providers - Molina Medicare

Molina Medicare of Ohio, Inc.
 PO Box 349020
 Columbus, OH 43234-9020

24 HOUR NURSE ADVICE LINE FOR MOLINA MEDICARE MEMBERS		
Services available in English and in Spanish.	English Telephone	(888) 275-8750
	Spanish Telephone	(866) 648-3537
	Hearing Impaired (TTY/TDD)	(866) 735-2929
CLAIMS AND CLAIMS APPEALS		
Mailing Address: Molina Medicare Options Plus Claims PO Box 22811 Long Beach, CA 90801	Telephone	(888) 665-1328
Physical Address for overnight packages: Molina Medicare 200 Oceangate, Suite 100 Long Beach, CA 90802		
COMPLIANCE/ANTI-FRAUD HOTLINE		
Confidential Compliance Official Molina Healthcare, Inc. 200 Oceangate, Suite 100 Long Beach, CA 90802	Telephone	(866) 665-4626
	Fax	(877) 665-4620
	Email	corporatecompliance@molinahealthcare.com
CREDENTIALING		
Molina Medicare of Ohio Credentialing Department PO Box 349020 Columbus, OH 43234-9020	Telephone	(800) 642-4168
	Fax	(614)781-1537
MOLINA MEDICARE INSIDE SALES AND PROSPECTIVE MEMBER ADVISORS		
Molina Medicare Inside Sales	Telephone	(866) 403-8293
	Hearing	(800) 346-4128

	Impaired (TTY/TDD)	
QUALITY IMPROVEMENT		
Molina Medicare - Ohio Quality Improvement Department PO Box 349020 Columbus, OH 43234-9020	Telephone	(800) 642-4168
	Fax	(614) 781-4464
UTILIZATION MANAGEMENT, REFERRALS & AUTHORIZATION		
Molina Medicare - Ohio Utilization Management PO Box 349020 Columbus, OH 43234-9020 Delegated services may include but not be limited to Claims, Utilization Management, Credentialing, Call Center and certain administrative functions that meet the criteria for delegation. Delegated entities shall comply with all state and federal requirements including but not limited to: <ul style="list-style-type: none"> • Reporting • Timeliness standards for organizational determinations • Training and education 	Telephone	(888) 665-1328
	Fax	(866) 449-6843
HEARING AND DENTAL		
Avesis Third Party Administrators 10324 S Dolfield Road Owings Mill, MD 21117	Telephone	Toll Free Phone (800) 327-4462
VISION		
March Vision Care 6701 Center Drive W Suite 790 Los Angeles, CA 90045	Telephone	Toll Free Phone (888) 493-4070
TRANSPORTATION		
Logisticare	Telephone	Toll Free 1-866-475-5423
	TTD/TTY	1-866-288-3133

IV. Eligibility and Enrollment in Molina Medicare Plans

A. Members who wish to enroll in Molina Medicare Options Plus (HMO SNP), a Medicare Advantage Prescription Drug Special Needs Plan, must meet the following eligibility criteria:

- Be entitled to Medicare Part A and enrolled in Medicare Part B;
- Not be medically determined to have ESRD prior to completing the enrollment form (unless individual is an existing Molina Medicaid member);
- Permanently reside in the Molina Medicare service area, which includes the following counties in 2013: Butler, Clark, Clermont, Delaware, Franklin, Greene, Hamilton, Madison, Miami, Montgomery, Morrow, Pickaway, Preble, Union, and Warren.
- Member or member's legal representative completes an enrollment election form completely and accurately;
- Is fully informed and agrees to abide by the rules of Molina Medicare;
- Is permitted to elect Molina Medicare according to the election rules that apply to the member; and
- Is entitled to Medicaid benefits as defined by the State of Ohio.

Further,

- Molina Medicare will not deny enrollment to a member who has elected the hospice benefit if the individual meets the other criteria for enrollment; and
- Molina Medicare will accept all Members that meet the above criteria and elect Molina Medicare during appropriate enrollment periods.

Further, Molina Medicare will not deny enrollment to a member who has elected the hospice benefit if the individual meets the other criteria for enrollment; and

- Molina Medicare will accept all members that meet the above criteria and elect Molina Medicare during appropriate enrollment periods.

B. Enrollment/Disenrollment Information

All members of **Molina Medicare Options Plus (HMO SNP)** are benefit dual eligible (e.g., they receive both Medicare and Medicaid). Centers for Medicare & Medicaid Services (CMS) rules state that these members may enroll or disenroll **throughout the year**.

C. Prospective Members Toll-Free Telephone Numbers

Existing Members may call our Member Services Department Monday-Sunday 8:00 a.m. to 8:00 p.m. local time. TTY/TDD users call 711.

CA – 1-800-665-0898

FL – 1-866-553-9494

IL – 1-888-665-1328

MI – 1-800-665-3072
NM – 1-866-440-0127
OH – 1-866-472-4584
TX – 1-866-440-0012
UT – 1-888-665-1328
UT – Healthy Advantage – 1-877-644-0344
WA – 1-800-665-1029

D. Effective Date of Coverage

The effective date of coverage for members will be the first day of the month following the acceptance of a complete enrollment form signed by the member or the member's authorized representative. An enrollment cannot be effective prior to the date the member or their legal representative signed the enrollment form or completed the enrollment election. During the applicable enrollment periods, if Molina Medicare receives a completed enrollment form on the last day of the month, Molina Medicare ensures that the effective date is the first day of the following month.

E. Disenrollment

Staff of Molina Medicare may never, verbally, in writing, or by any other action or inaction, request or encourage a Medicare member to disenroll except when the member has:

- Permanently moved outside Molina's service area;
- Committed fraud;
- Abused their membership card;
- Displayed disruptive behavior;
- Lost Medicaid eligibility (for dual eligible enrolled in Molina Medicare's Special Needs Plan); and/or
- Lost Medicare Part A or B.

When members permanently move out of Molina's service area or leave Molina's service area for over six (6) consecutive months, they must disenroll from Molina Medicare. There are a number of ways that the Molina Medicare Membership Accounting Department may be informed that the member has relocated:

- Out-of-area notification will be received from CMS on the monthly membership report;
- The member may call to advise Molina Medicare that they have relocated; and/or
- Other means of notification may be made through the Claims Department, if out-of-area claims are received with a residential address other than the one on file. (Molina Medicare does not offer a visitor/traveler program to Members).

F. Requested Disenrollment

Molina Medicare will process disenrollment of members from the health plan only as allowed by CMS regulations. Molina Medicare will request that a member be disenrolled under the following circumstances:

- Member requests disenrollment; (during a valid election period);
- Member enrolls in another plan (during a valid enrollment period);
- Member provided fraudulent information on the election form; and/or
- Member has engaged in disruptive behavior, which is defined as behavior that substantially impairs the plan’s ability to arrange for or provide services to the individual or other plan members. An individual cannot be considered disruptive if such behavior is related to the use of medical services or compliance (or noncompliance) with medical advice or treatment.

Other reasons for the disenrollment may be one of the following:

- Member abuses the enrollment card by allowing others to use it to fraudulently obtain services;
- Member leaves the service area and directly notifies Molina Medicare of the permanent change of residence;
- Member has not permanently moved but has been out of the service area for six (6) months or more, Molina Medicare will request that the member be disenrolled;
- Member loses entitlement to Medicare Part A or Part B benefits;
- Member loses Medicaid eligibility;
- Molina Medicare loses or terminates its contract with CMS. In the event of plan termination by CMS, Molina Medicare will send CMS approved notices and a description of alternatives for obtaining benefits. The notice will be sent timely, before the termination of the plan; and/or
- Molina Medicare discontinues offering services in specific service areas where the member resides.

In all circumstances except death, Molina Medicare will provide a written notice to the member with an explanation of the reason for the disenrollment. All notices will be in compliance with CMS regulations and will be approved by CMS. Each notice will include the process for filing a grievance.

In the event of death, a verification of disenrollment will be sent to the deceased member’s estate.

G. Member Identification Card Example – Medical Services

<p>Molina Medicare Member: Member #:</p> <hr/> <p>PCP: PCP Phone: Medical Copays: Office Visits: Specialist Visits: Urgent Care: ER Visits:</p> <p>RxBIN: RXPCN: RxGrp: RxID:</p> <p>MedicareRx Prescription Drug Coverage</p> <p>Issue ID: Issued Date:</p> <p>H5628-001</p>	<p>Member Services: 1-800-665-3086 or TTY at 1-800-346-4128 Monday – Sunday, 8:00 AM to 8:00 PM local time. 24-Hour Nurse Advice Line: 1-888-275-8750 24-Hour Nurse Advice Line TTY: 1-866-735-2922 For Spanish Please Call: 866-648-3537. Providers/Hospitals: For prior authorization, eligibility and general information, please call Member Services (see above). Submit Claims To: Medical/Hospital: PO BOX 22811, Long Beach, CA 90801 please call Member Services (see above). Pharmacy: 7050 Union Park Ave, Suite 200, Midvale, UT 84047 please call Member Services (see above). www.molinamedicare.com</p>
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H. Member Identification Card Example – Dental Services



**Your Dental ID # is the same as
your Member ID #**

To obtain a list of network dentists,
call 1-855-214-6779 TTY/TDD 711
or visit <http://www.avesis.com/>

A health plan with a Medicare Contract.
A Coordinated Care plan with a
Medicare Advantage contract and a
contract with the state Medicaid program.

For Dentists:
Avesis offers access to Avesis's Network

Submit claims to:
Avesis/Claims Department
P.O. Box 7777
Phoenix, AZ 85011-7777
Or electronically via the website below.

For benefit, eligibility or claim information,
please call 1-855-214-6779 TTY/TDD 711 or
visit <http://www.avesis.com/>.

I. Verifying Eligibility

To ensure payment, Molina Medicare strongly encourages providers to verify eligibility at every visit and especially prior to providing services that require authorization. Possession of the ID card does not guarantee Member eligibility or coverage. It is the responsibility of the practitioner/provider to verify the eligibility of the cardholder.

Dual Eligibles and Cost-Share: Molina SNP Plans in CA and TX:

Molina allows only Members who are entitled to full Medicare and Medicaid benefits to enroll in California and Texas plans. These Members have \$0 copays for Medicare covered services.

Dual Eligibles and Cost Share: Molina SNP Plans in All Other States:

Molina allows Members to enroll who have all levels of Medicaid assistance. These Members may or may not be entitled to cost-share assistance, and may or may not have Medicaid benefits. Providers can find cost-share information on an individual Molina SNP Member through the Molina Provider Portal at www.molinahealthcare.com. Below is a cost-share chart to reference:

Cost-Share Grid <i>Applies to all Molina Medicare/Healthy Advantage states except CA and TX</i> <i>CA and TX are \$0 cost-share plans</i>		
Type	Member's Cost-Share	Preventive
QMB	0%	0%
QMB+	0%	0%
SLMB	20% (Medicare Part A and B deductibles apply)	0%
SLMB+	0% When service is covered by both Medicare and Medicaid Otherwise 20% (Medicare Part A and B deductibles apply if 20%)	0%
QI	20% (Medicare Part A and B deductibles apply)	0%
QDWI	20% (Medicare Part A and B deductibles apply]	0%
FBDE	0% When service is covered by both Medicare and Medicaid Otherwise 20% (Medicare Part A and B deductibles apply if 20%)	0%
No Medi	20% (Medicare Part A and B deductibles apply)	0%
Dual, No Medi	20% (Medicare Part A and B deductibles apply)	0%
Unknown	Unknown; assess 0% at time of service, check back 2 nd week of following month	0%

V. Benefit Overview

A. Questions about Molina Medicare Benefits

If there are questions as to whether a service is covered or requires prior authorization, please contact **Molina Medicare Member Services Department Monday through Sunday 8:00 a.m. to 8:00 p.m. toll free at (866) 472-4584 or 711 for persons with hearing impairments (TTY/TDD).**

B. Links to Summaries of Benefits

The following web link provides the **Summary of Benefits** for the 2013 Molina Medicare Options Plus Special Needs Plan (HMO SNP) plan in Ohio:

[2013 Molina Medicare Options Plus Special Needs - Summary of Benefits](#)

C. Links to Evidence of Coverage

Detailed information about benefits and services can be found in the 2013 **Evidence of Coverage booklets** sent to each Molina Medicare Member.

The following web link provides the **Evidence of Coverage** for the 2013 Molina Medicare Options Plus Special Needs Plan (HMO SNP) plan in Ohio:

[2013 Molina Medicare Options Plus Special Needs - Evidence of Coverage](#)

- D. Please note for 2013: The Medicare-covered initial preventive and physical examination (IPPE) and the annual wellness visit are covered at zero cost sharing. Our plans cover Medicare-covered preventive services at no cost to the member.

VI. Quality Improvement

Molina Medicare maintains a Quality Improvement (QI) Department to work with Members and providers in administering the Molina Medicare Quality Improvement Program. You can contact the Molina Medicare QI Department **toll free at (800) 642-4168**.

The address for mail requests is:

**Molina Medicare of Ohio
Quality Improvement Department
PO Box 349020
Columbus, OH 43234-9020**

This Provider Manual contains excerpts from the Molina Medicare Quality Improvement Program Description (QIPD). For a complete copy, please contact your Provider Services Representative or call the telephone number above.

Molina Medicare has established a QIPD that complies with regulatory and accreditation guidelines. The Quality Improvement Program provides structure and outlines specific activities designed to improve the care, service and health of members.

Molina Medicare does not delegate Quality Improvement activities to Medical Groups/Independent Practice Association (IPAs) or delegated entities. However, Molina Medicare requires contracted Medical Groups/IPAs and other delegated entities comply with the following core elements and standards of care and to:

- Have a quality improvement program in place;
- Comply with and participate in Molina Medicare's Quality Improvement Program including reporting of Access and Availability and provision of medical records as part of the quality of care, quality improvement and HEDIS® reporting activities; and
- Allow access to Molina Medicare QI personnel for site and medical record keeping and documentation practices.

A. Patient Safety Program

Molina Medicare's Patient Safety Program identifies appropriate safety projects and error avoidance for Molina Medicare members in collaboration with their primary care practitioners. Molina Medicare continues to support safe personal health practices for our members through our safety program, pharmaceutical management and case management/disease management programs and education. Molina monitors nationally recognized quality index ratings for facilities including adverse events and hospital acquired conditions as part of a national strategy to improve health care quality mandated by the Patient Protection and Affordable Care Act (ACA), Health and Human Services (HHS) is to identify areas that have the potential for improving health care quality to reduce the incidence of events.

The Tax Relief and Health Care Act of 2006 mandates that the Office of Inspector General report to Congress regarding the incidence of “never events” among Medicare beneficiaries, the payment for services in connection with such events, and the Centers for Medicare & Medicaid Services (CMS) processes to identify events and deny payment.

B. Quality of Care

Molina Medicare has an established and systematic process to identify, investigate, review and report any Quality of Care, Adverse Event/Never Event, and/or service issues affecting member care. Molina Medicare will research, resolve, track and trend issues. Confirmed Adverse Events/Never Events are reportable when related to an error in medical care that is clearly identifiable, preventable and/or found to have caused serious injury or death to a patient. Some examples of never events include:

- Surgery on the wrong body part
- Surgery on the wrong patient
- Wrong surgery on a patient

Molina Medicare is not required to pay for inpatient care related to “never events”.

C. Medical Records

Molina Medicare requires that medical records are maintained in a manner that is current, detailed and organized to ensure that care rendered to Members is consistently documented and that necessary information is accurate and readily available in the medical record. Molina Medicare conducts a medical record review of Primary Care Practitioners (PCPs) every three (3) years that includes the following components:

- Medical record confidentiality and release of medical records including mental/behavioral healthcare records;
- Medical record content and documentation standards, including preventive health care;
- Storage maintenance and disposal; and
- Process for archiving medical records and implementing improvement activities.

Providers must demonstrate compliance with Molina Medicare’s medical record documentation guidelines. Medical records are assessed based on the following standards:

1. Content

- Patient name or ID is on all pages;
- Current biographical data is maintained in the medical record or database;
- All entries contain author identification;
- All entries are dated: Medication allergies and adverse reactions are prominently displayed. Absence of allergies is noted in easily recognizable location;
- Chronic conditions are listed or noted in easily recognizable location;
- Past medical history for patients seen more than three (3) times is noted;
- There is appropriate notation concerning use of substances, and for patients seen three (3) or more times, there is evidence of substance abuse query;

- The history and physical examination identifies appropriate subjective and objective information pertinent to a patient's presenting complaints;
- Consistent charting of treatment care plan;
- Working diagnoses are consistent with findings;
- Treatment plans are consistent with diagnoses;
- Encounter notation includes follow up care, call, or return instructions;
- Preventive health measures (e.g., immunizations, mammograms, etc.) are noted;
- A system is in place to document telephone contacts;
- Lab and other studies are ordered as appropriate;
- Lab and other studies are initialed by ordering provider upon review;
- Lab results and other studies are filed in chart;
- If patient was referred for consult, therapy, or ancillary service, a report or notation of result is noted at subsequent visit, or filed in medical record; and
- If the provider admitted a patient to the hospital in the past twelve (12) months, the discharge summary must be filed in the medical record.

2. Organization

- The medical record is legible to someone other than the writer;
- Each patient has an individual record;
- Chart pages are bound, clipped, or attached to the file; and
- Chart sections are easily recognized for retrieval of information.

3. Retrieval

- The medical record is available to provider at each encounter;
- The medical record is available to Molina Medicare for purposes of quality improvement;
- Medical record retention process is consistent with state and federal requirements; and
- An established and functional data recovery procedure in the event of data loss.

4. Confidentiality

- Medical Records are protected from unauthorized access;
- Access to computerized confidential information is restricted; and
- Precautions are taken to prevent inadvertent or unnecessary disclosure of protected health information.

Additional information on medical records is available from your local Molina Medicare Quality Improvement Department **toll free at (800) 642-4168**. See also Chapter VII regarding the Health Insurance Portability and Accountability Act (HIPAA).

D. Access to Care

Molina Medicare is committed to timely access to care for all Members in a safe and healthy environment. Providers are required to conform to the Access to Care appointment standards listed below to ensure that healthcare services are provided in a timely manner.

- 1. Appointment Access** - All providers who oversee the member’s health care are responsible for providing the following appointments to Molina Medicare members in the timeframes noted:

Primary Care Practitioner (PCP)	
Types of Care for Appointment	Appointment Wait Time (Appointment Standards)
Emergency Care	Immediate
Acute/Urgent Care	Members with persistent symptoms must be treated no later than the end of the following working day after their initial contact with the PCP office.
Preventive Care Appointment	Within thirty (30) days of request
Routine Primary Care	Within fourteen (14) days of request
After Hours Care	
After-Hours Instruction/Standards	
After hours emergency instruction	Members who call Member Services are instructed if this is an emergency, please hang up and dial 911
After-Hours Care	Available by telephone twenty-four (24) hours/seven (7) days
Specialty Care Provider (SCP)	
Types of Care for Appointment	Appointment Wait Time (Appointment Standards)
Routine Care	Within twenty one (21) days of request
Mental/Behavioral Health	
Types of Care for Appointment	Appointment Wait Time (Appointment Standards)
Non-life Threatening Emergency Care	Within ≤ six (6) hours of request
Urgent Care	Within ≤ twenty-four (24) hours of request
Routine Care	Within ≤ ten (10) working days of request

Additional information on appointment access standards is available from your local Molina Medicare QI Department **toll free at (800) 642-4168.**

- 2. Office Wait Time** - For scheduled appointments, the wait time in offices should not exceed thirty (30) minutes from appointment time until the time seen by the PCP. All PCPs are required to monitor waiting times and to adhere to this standard.
- 3. After Hours** - All providers must have back-up (on call) coverage after hours or during the provider’s absence or unavailability. Molina Medicare requires providers to maintain a twenty-four (24) hour telephone service, seven (7) days a week. This access may be through an answering service or a recorded message after office hours. The service or

recorded message should instruct Members with an emergency to hang-up and call 911 or go immediately to the nearest emergency room.

- 4. Appointment Scheduling** - Each provider must implement an appointment scheduling system. The following are the minimum standards:
- a.** The provider must have an adequate telephone system to handle patient volume. Appointment intervals between patients should be based on the type of service provided and a policy defining required intervals for services. Flexibility in scheduling is needed to allow for urgent walk-in appointments;
 - b.** A process for documenting missed appointments must be established. When a member does not keep a scheduled appointment, it is to be noted in the member's record and the provider is to assess if a visit is still medically indicated. All efforts to notify the member must be documented in the medical record. If a second appointment is missed, the provider is to notify the Molina Medicare Member Services Department **toll free at (866) 472-4584 or 711 for TTY/TDD**;
 - c.** When the provider must cancel a scheduled appointment, the member is given the option of seeing an associate or having the next available appointment time;
 - d.** Special needs of Members must be accommodated when scheduling appointments. This includes, but is not limited to wheelchair-bound Members and Members requiring language translation;
 - e.** A process for member notification of preventive care appointments must be established. This includes, but is not limited to, immunizations and mammograms; and
 - f.** A process must be established for member recall in the case of missed appointments for a condition which requires treatment, abnormal diagnostic test results or the scheduling of procedures which must be performed prior to the next visit.

In applying the standards listed above, participating providers have agreed that they will not discriminate against any member on the basis of age, race, creed, color, religion, sex, national origin, sexual orientation, marital status, physical, mental or sensory handicap, and place of residence, socioeconomic status, or status as a recipient of Medicaid benefits. Additionally, a participating provider or contracted medical group/IPA may not limit his/her practice because of a member's medical (physical or mental) condition or the expectation for the need of frequent or high cost care. If a PCP chooses to close his/her panel to new Members, Molina must receive thirty (30) days advance written notice from the provider.

- 5. Monitoring Access for Compliance with Standards** - Molina Medicare monitors compliance with the established access standards above. At least annually, Molina Medicare conducts an access audit of randomly selected contracted provider offices to determine if appointment access standards are met. One or all of the following appointment scenarios may be addressed: routine care; acute care; preventive care; and after-hours information. Results of the audit are distributed to the providers after its completion. A corrective action plan may be required if standards are not met.

In addition, Molina Medicare's Member Services Department reviews member inquiry logs and grievances related to delays in access to care. These are reported quarterly to committees. Delays in access that may create a potential quality issue are sent to the QI Department for review.

Additional information on access to care is available under the Resources tab available from your local Molina Medicare Quality Improvement Department **toll free at (800)642-4168**.

E. Advance Directives (Patient Self-Determination Act)

Providers must inform patients of their right to make health care decisions and execute advance directives. It is important that members are informed about advance directives. During routine Medical Record review, Molina Medicare auditors will look for documented evidence of discussion between the provider and the member. Molina Medicare will notify the Provider of an individual member's advance directives identified through care management, Care Coordination or Case Management. Providers are instructed to document the presence of an advance directive in a prominent location of the Medical Record. Auditors will also look for copies of the form. Advance directives forms are state specific to meet state regulations. For copies of forms applicable to your state, please go to the Caring Connections website at www.caringinfo.org for forms available to download. Additionally, the Molina Medicare website offers information to both providers and Members regarding advance directives, with a link to forms that can be downloaded and printed.

Advance directives are a written choice made by a patient for health care treatment. There are two (2) kinds of directives – Durable Power of Attorney for Health Care and Directive to Physicians. Written advance directives tell the PCP and other medical providers how Members choose to receive medical care in the event that they are unable to make end-of life decisions.

Each Molina Medicare Provider must honor advance directives to the fullest extent permitted under law. PCPs must discuss advance directives with a member and provide appropriate medical advice if the member desires guidance or assistance. Molina Medicare's network providers and facilities are expected to communicate any objections they may have to a member directive prior to service whenever possible. In no event may any provider refuse to treat or otherwise discriminate against a member because the member has completed an advance directive. Medicare law gives Members the right to file a complaint with Molina Medicare or the state survey and certification agency if the member is dissatisfied with Molina Medicare's handling of advance directives and/or if a provider fails to comply with advance directive instructions.

Durable Power of Attorney for Health Care: This advance directive names another person to make medical decisions on behalf of the member when they cannot make the choices for themselves. It can include plans about the care a member wants or does not want and includes information concerning artificial life-support machines and organ donations. This form must be signed, dated and witnessed by a notary public to be valid.

Directive to Physicians (Living Will): This advance directive usually states that the member wants to die naturally without life-prolonging care and can also include information about any desired medical care. The form would be used if the member could not speak and death would occur soon. This directive must be signed, dated and witnessed by two (2) people who know the member well but are not relatives, possible heirs, or healthcare providers.

When There Is No Advance Directive: The member's family and provider will work together to decide on the best care for the member based on information they may know about the member's end-of-life plans.

F. Quality Improvement Activities and Programs

Molina Medicare maintains an active Quality Improvement Program (QIP). The QIP provides structure and key processes to carry out our ongoing commitment to improvement of care and service. The goals identified are based on an evaluation of programs and services; regulatory, contractual and accreditation requirements; and strategic planning initiatives.

1. Disease Management Programs - Molina Medicare has established disease management programs to measure and improve health status and quality of life. The Disease Management Programs involve a collaborative team approach comprised of health education, clinical case management and provider education. The team works closely with contracted providers in the identification, assessment and implementation of appropriate interventions. Currently these programs are made available to all eligible Molina Medicare Members based on inclusion criteria, and to all network providers.

- Heart Healthy Living Program
(Addresses High Blood Pressure, Coronary Artery Disease and/or Congestive Heart Failure)
- Healthy Living with Diabetessm Program
- Healthy Living with Chronic Obstructive Pulmonary Disease
- Breathe with Easesm Asthma Program
- Medication Therapy Management
- Smoking Cessation

a. Program Eligibility Criteria and Referral Source - Disease Management Programs are designed for active Molina Medicare Members with a confirmed diagnosis. Members participate in programs for the duration of their eligibility with the plan's coverage or until the member opts out. Each identified member will receive specific educational materials and other resources in accordance with their assigned stratification level. Additionally, all identified Members will receive regular educational newsletters. The program model provides an "opt-out" option for Members who contact Molina Medicare Member Services and request to be removed from the program.

Multiple sources are used to identify the total eligible population. These include the following:

- Pharmacy claims data for all classifications of medications;

- Encounter data or paid claim with a relevant CPT-4 or ICD-9 code;
- Member Services welcome calls made by staff to new member households and incoming member calls have the potential to identify eligible program participants. Eligible Members are referred to the program registry;
- Provider referral;
- Medical Case Management or Utilization Management; and
- Member self-referral due to general plan promotion of program through member newsletter, the Molina Healthcare Nurse Advice Line or other member communication.

b. Provider Participation - Contracted providers are automatically notified whenever their patients are enrolled in a disease management program. Provider resources and services may include:

- Annual provider feedback letters containing a list of patients identified with the relevant disease;
- Clinical resources such as patient assessment forms and diagnostic tools;
- Patient education resources such as booklets, magnets, CDs, DVDs, etc.;
- Provider Newsletters promoting the disease management programs, including how to enroll patients and outcomes of the programs;
- Clinical Practice Guidelines; and
- Preventive Health Guidelines.

Additional information on disease management programs is available from your local Molina Medicare QI Department **toll free at (800) 642-4168**.

2. Clinical Practice Guidelines - Molina Medicare adopts and disseminates Clinical Practice Guidelines (CPGs) to reduce inter-provider variation in diagnosis and treatment. CPG adherence is measured at least annually. All guidelines are based on scientific evidence, review of medical literature and/or appropriate established authority. Clinical Practice Guidelines are reviewed annually and are updated as new recommendations are published.

Molina Medicare Clinical Practice Guidelines include the following:

- Coronary Artery Disease and/or Congestive Heart Failure
- Hypertension
- Diabetes
- Chronic Obstructive Pulmonary Disease
- Asthma
- Cholesterol Management
- Depression
- Substance Abuse Treatment

The adopted Clinical Practice Guidelines are distributed to the appropriate providers, provider groups, staff model facilities, delegates and Members by the Quality Improvement, Provider Services, Health Education and Member Services Departments. The guidelines are disseminated through provider newsletters, Just the Fax electronic

bulletins and other media and are available on the Molina Medicare Website. Individual providers or Members may request copies from your local Molina Medicare QI Department toll free at **(800) 642-4168**.

- 3. Preventive Health Guidelines** - Molina Medicare provides coverage of diagnostic preventive procedures based on recommendations published by the U.S. Preventive Services Task Force (USPSTF) and in accordance with Centers for Medicare & Medicaid Services (CMS) guidelines. Diagnostic preventive procedures include but are not limited to:

- Mammography Screening;
- Prostate cancer screening;
- Cholesterol screening;
- Colorectal screening; or
- Influenza, pneumococcal and hepatitis vaccines.

All guidelines are updated with each release by USPSTF and are approved by the Quality Improvement Committee. On annual basis, Preventive Health Guidelines are distributed to providers via www.MolinaMedicare.com and the Provider Manual. Notification of the availability of the Preventive Health Guidelines is published in the Molina Medicare Provider Newsletter.

- 4. Cultural and Linguistic Services** - Molina Medicare serves a diverse population of Members with specific cultural needs and preferences. Providers are responsible to ensure that interpreter services are made available at no cost for Members with sensory impairment and/or who are Limited English Proficient (LEP). The following cultural and linguistic services are offered by Molina Medicare to assist both Members and providers.

- a. 24 Hour Access to Interpreter** - Providers may request interpreters for Members whose primary language is other than English by calling **Molina Medicare's Member Services Department toll free at (866) 472-4584**. If Member Services Representatives are unable to provide the interpretation services internally, the member and provider are immediately connected to Language Line telephonic interpreter service.

If a member is not willing to use an interpreter and requests a family member as an interpreter after being notified of his or her right to have a qualified interpreter at no cost, document their request in their medical record. Molina Medicare is available to assist you in notifying Members of their right to an interpreter. All counseling and treatment done via an interpreter should be noted in the medical record by stating that such counseling and treatment was done via interpreter services. Providers should document who provided the interpretation service. That information could be the name of their internal staff or someone from a commercial vendor such as Language Line. Information should include the interpreter's name, operator code number and vendor.

- b. Face-to-Face Interpretation** – [Providers may request face-to-face interpretation for scheduled medical visits, if required, due to the complexity of information exchange or when requested by the member. To request face-to-face interpretation services, please contact the Health Education Department. Additional information on cultural and linguistic services is available at www.MolinaMedicare.com from your local Provider Services Representatives and from the Molina Medicare Member Services Department.
- c. Members with Hearing Impairment** - Molina provides a TTY connection, which may be reached by dialing **711**. This connection provides access to Member Services, Quality Improvement, Utilization Management and all other health plan functions.

The Molina Nurse Advice Line may be reached via a TTY connection by dialing **711**.

G. Measurement of Clinical and Service Quality

Molina Medicare monitors and evaluates the quality of care and services provided to Members through the following mechanisms:

- Healthcare Effectiveness Data and Information Set (HEDIS®);
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®);
- Health Outcomes Survey (HOS);
- Provider Satisfaction Survey; and
- Effectiveness of Quality Improvement Initiatives.

Molina Medicare’s most recent results can be obtained from your local Molina Medicare QI Department **toll free at (800) 642-4168**.

- 1. Healthcare Effectiveness Data and Information Set (HEDIS®)** - Molina Medicare utilizes the NCQA© HEDIS® as a measurement tool to provide a fair and accurate assessment of specific aspects of managed care organization performance. HEDIS® is an annual activity conducted in the spring. The data comes from on-site medical record review and available administrative data. All reported measures must follow rigorous specifications and are externally audited to assure continuity and comparability of results. The HEDIS® measurement set currently includes a variety of health care aspects including immunizations, women’s health screening, diabetes care, glaucoma screening, medication use and cardiovascular disease.

HEDIS® results are used in a variety of ways. They are the measurement standard for many of Molina Medicare’s clinical quality improvement activities and health improvement programs. The standards are based on established clinical guidelines and protocols, providing a firm foundation to measure the success of these programs.

Selected HEDIS® results are provided to regulatory and accreditation agencies as part of our contracts with these agencies. The data are also used to compare to established health plan performance benchmarks.

- 2. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) -** CAHPS® is the tool used by Molina Medicare to summarize member satisfaction with the health care and service they receive. CAHPS® examines specific measures, including Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Health Promotion and Education, Coordination of Care and Customer Service. The CAHPS® survey is administered annually in the spring to randomly selected Members by a NCQA certified vendor.

CAHPS® results are used in much the same way as HEDIS® results, only the focus is on the service aspect of care rather than clinical activities. They form the basis for several of Molina Medicare's quality improvement activities and are used by external agencies to help ascertain the quality of services being delivered.

- 3. Medicare Health Outcomes Survey (HOS) -** The HOS measures Medicare Members' physical and mental health status over a two (2)-year period and categorizes the two (2)-year change scores as better, same, or worse than expected. The goal of the HOS is to gather valid, reliable, clinically meaningful data that can be used to target quality improvement activities and resources, monitor health plan performance and reward top performing health plans. Additionally, the HOS is used to inform beneficiaries of their healthcare choices, advance the science of functional health outcomes measurement, and for quality improvement interventions and strategies.
- 4. Provider Satisfaction Survey -** Recognizing that HEDIS® and CAHPS® both focus on member experience with healthcare providers and health plans, Molina Medicare conducts a Provider Satisfaction Survey annually. The results from this survey are very important to Molina Medicare, as this is one of the primary methods used to identify improvement areas pertaining to the Molina Provider Network. The survey results have helped establish improvement activities relating to Molina Medicare's specialty network, inter-provider communications, and pharmacy authorizations. This survey is fielded to a random sample of providers each year. If your office is selected to participate, please take a few minutes to complete and return the survey.
- 5. Effectiveness of Quality Improvement Initiatives -** Molina Medicare monitors the effectiveness of clinical and service activities through metrics selected to demonstrate clinical outcomes and service levels. The plan's performance is compared to that of available national benchmarks indicating "best practices." The evaluation includes an assessment of clinical and service improvements on an ongoing basis. Results of these measurements guide activities for the successive periods.

Contracted Providers and Facilities must allow Molina Medicare to use its performance data collected in accordance with the provider's or facility's contract. The use of performance data may include, but is not limited to, the following: (1) development of quality improvement activities; (2) public reporting to consumers; (3) preferred status designation in the network; (4) and/or reduced member cost sharing.

H. Medicare Star Ratings - The Affordable Care Act

With the passage of the Affordable Care Act, the healthcare industry will be subject to greater scrutiny wherever taxpayer dollars are involved. One method of oversight is Medicare “Star Ratings.” Star ratings are not new, but in the current regulatory climate, value-based payment will be receiving more focus.

Star Ratings are a system of measurements CMS uses to determine how well physicians and health plans are providing care to Medicare members. This system is based on nationally-recognized quality goals such as “The Triple Aim” and the Institute of Medicine’s “Six Aims,” which focus on improving the health and care of your patients, safe and effective care, as well as making care affordable. These aims are realized through specific measures.

Preventive Health:

- Annual wellness/physical exams
- Glaucoma
- Mammography
- Osteoporosis
- Influenza and Pneumonia Immunizations

Chronic Care Management:

- Diabetes management screenings
- Cardiovascular and hypertension management screenings
- Medication adherence for chronic conditions
- Rheumatoid arthritis management

Member Satisfaction Survey Questions:

- “...rate your satisfaction with your personal doctor”
- “...rate your satisfaction with getting needed appointments”

A HEDIS CPT/ICD-9 code sheet is available at www.MolinaMedicare.com

What Can Providers Do?

- Ensure patients are up-to-date with their annual physical exam and preventive health screenings, including related lab orders and referrals to specialists, such as ophthalmology;
- Review the HEDIS® preventive care listing of measures for each patient to determine if anything applicable to your patients’ age and/or condition has been missed;
- Check that staff is properly coding all services provided; and
- Be sure patients understand what *they* need to do.

Molina Medicare has additional resources to assist providers and their patients.

For access to tools that can assist, please go to www.MolinaMedicare.com and click on Providers. There is a variety of resources, including:

- HEDIS® CPT/ICD-9 code sheet
- A current list of HEDIS® & CAHPS® Star Ratings measures

HEDIS® and CAHPS® are registered trademarks of the National Committee for Quality Assurance (NCQA).

VII. The Health Insurance Portability and Accountability Act (HIPAA)

A. Molina Medicare's Commitment to Patient Privacy

Protecting the privacy of Members' personal health information is a core responsibility that Molina Medicare takes very seriously. Molina Medicare is committed to complying with all federal and state laws regarding the privacy and security of Members' protected health information (PHI).

B. Provider Responsibilities

Molina Medicare expects that its contracted providers will respect the privacy of Molina Medicare Members and comply with all applicable laws and regulations regarding the privacy of patient and member PHI.

C. Applicable Laws

Providers must understand all state and federal healthcare privacy laws applicable to their practice and organization. Currently, there is no comprehensive regulatory framework that protects all health information in the United States; instead there is a patchwork of laws that providers must comply with. In general, most healthcare providers are subject to various laws and regulations pertaining to privacy of health information including, without limitation, the following:

1. Federal Laws and Regulations

- HIPAA; and
- Medicare and Medicaid laws.

2. State Medical Privacy Laws and Regulations - Providers should be aware that HIPAA provides a floor for patient privacy but that state laws should be followed in the event state law is more stringent than HIPAA. Providers should consult with their own legal counsel to address their specific situation.

D. Uses and Disclosures of PHI

Member and patient PHI should be used or disclosed only as permitted or required by applicable law. Under HIPAA, a provider may use and disclose PHI for their own *treatment*, *payment*, and healthcare *operations* activities (TPO) without the consent or authorization of the patient who is the subject of the PHI.

Uses and disclosures for TPO apply not only to the provider's own TPO activities, but also for the TPO of another covered entity. (See, Sections 164.506(c)(2) & (3) of the HIPAA Privacy Rule.) Disclosure of PHI by one covered entity to another covered entity, or

healthcare provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

1. A covered entity may disclose PHI to another covered entity or a healthcare provider for the payment activities of the recipient. Please note that payment is a defined term under the HIPAA Privacy Rule that includes, without limitation, utilization review activities, such as preauthorization of services, concurrent review, and retrospective review of "services." (See the definition of Payment, Section 164.501 of the HIPAA Privacy Rule).
2. A covered entity may disclose PHI to another covered entity for the healthcare operations activities of the covered entity that receives the PHI, if each covered entity either has or had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship, and the disclosure is for the following healthcare operations activities:
 - Quality improvement;
 - Disease management;
 - Case management and care coordination;
 - Training Programs; or
 - Accreditation, licensing, and credentialing

Importantly, this allows providers to share PHI with Molina Medicare for our healthcare operations activities, such as HEDIS and quality improvement.

E. Written Authorizations

Uses and disclosures of PHI that are not permitted or required under applicable law require the valid written authorization of the patient. Authorizations should meet the requirements of HIPAA and applicable state law. A sample Authorization for the Use and Disclosure of Protected Health Information is included at the end of this section.

F. Patient Rights

Patients are afforded various rights under HIPAA. Molina providers must allow patients to exercise any of the below-listed rights that apply to the provider's practice:

1. **Notice of Privacy Practices** – Providers that are covered under HIPAA and that have a direct treatment relationship with the patient should provide patients with a notice of privacy practices that explains the patient's privacy rights and the process the patient should follow to exercise those rights. The provider should obtain a written acknowledgment that the patient received the notice of privacy practices.
2. **Requests for Restrictions on Uses and Disclosures of PHI** – Patients may request that a healthcare provider restrict its uses and disclosures of PHI. The provider is not required to agree to any such request for restrictions.

- 3. Requests for Confidential Communications** – Patients may request that healthcare providers communicate PHI by alternative means or at alternative locations. Providers must accommodate reasonable requests by the patient.
- 4. Requests for Patient Access to PHI** – Patients have a right to access their own PHI within a provider’s designated record set. Personal representatives of patients have the right to access the PHI of the subject patient. The designated record set of a provider includes the patient’s medical record, as well as billing and other records used to make decisions about the member’s care or payment for care.
- 5. Request to Amend PHI** – Patients have a right to request that the provider amend information in their designated record set.
- 6. Request Accounting of PHI Disclosures** – Patients may request an accounting of disclosures of PHI made by the provider during the preceding six (6) year period. The list of disclosures does not need to include disclosures made for treatment, payment, or healthcare operations or made prior to April 14, 2003.

G. HIPAA Security

HIPPA requires Providers to implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of member PHI. Providers should recognize that identity theft is a rapidly growing problem and that their patients trust them to keep their most sensitive information private and confidential.

In addition, medical identity theft is an emerging threat in the healthcare industry. Medical identity theft occurs when someone uses a person’s name and sometimes other parts of their identity - such as health insurance information - without the person’s knowledge or consent to obtain healthcare services or goods. Medical identity theft frequently results in erroneous entries being put into existing medical records. Providers should be aware of this growing problem and report any suspected fraud to Molina Medicare.

H. HIPAA Transactions and Code Sets

Molina Medicare strongly supports the use of electronic transactions to streamline healthcare administrative activities. Molina Medicare providers are encouraged to submit claims and other transactions using electronic formats. Certain electronic transactions are subject to HIPAA’s Transactions and Code Sets Rule including, but not limited to, the following:

- Claims and encounters;
- Member eligibility status inquiries and responses;
- Claims status inquiries and responses;
- Authorization requests and responses; and
- Remittance advices.

Molina Medicare is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers who wish to conduct HIPAA standard transactions with Molina Medicare should refer to:

<http://www.molinahealthcare.com/medicaid/providers/tx/hipaa/Pages/home.aspx>

I. National Provider Identifier

Providers must comply with the National Provider Identifier (NPI) Rule promulgated under HIPAA. The provider must obtain an NPI from the National Plan and Provider Enumeration System (NPPES) for itself or for any subparts of the provider. The provider must report its NPI and any subparts to Molina Medicare and to any other entity that requires it. Any changes in its NPI or subparts information must be reported to NPPES within thirty (30) days and should also be reported to Molina Medicare within thirty (30) days of the change. Providers must use their NPI to identify it on all electronic transactions required under HIPAA and on all claims and encounters (both electronic and paper formats) submitted to Molina Medicare.

J. Additional Requirements for Delegated Providers Entities

Providers that are delegated for claims, credentialing, utilization management, call center or any combination of these functions, are the “business associates” of Molina. Under HIPAA, Molina must obtain contractual assurances from all business associates that they will safeguard member PHI. Delegated Providers must agree to various contractual provisions required under HIPAA’s Privacy and Security Rules.

VIII. Utilization Management

Molina Medicare maintains a Utilization Management (UM) Department to work with Members and providers in administering the Molina Medicare Utilization Management Program. You can contact the Molina Medicare UM Department for **toll free at (800) 642-4168**.

The address for mail requests is:

Molina Medicare
Molina Healthcare of Ohio, Inc.
PO Box 349020
Columbus, OH 43234-9020

This Molina Provider Manual contains excerpts from the Molina Medicare Utilization Management Program Description (UMPD). For a complete copy of your state's Molina Medicare UMPD you can access the Molina Medicare website at www.MolinaMedicare.com or contact the telephone number above to receive a written copy. You can always find more information about Molina Medicare UM including information about obtaining a copy of clinical criteria used for authorizations and how to contact a UM reviewer by accessing www.MolinaMedicare.com or calling the UM Department at the number listed above.

Molina Medicare's Utilization Management (UM) Program is designed to provide comprehensive healthcare management. This focus, from prevention through treatment, benefits the entire care delivery system by effectively and efficiently managing existing resources to ensure quality care. It also ensures that care is both medically necessary and demonstrates an appropriate use of resources based on the severity of illness and the site of service. Molina Medicare works in partnership with Members and providers to promote a seamless delivery of healthcare services. Molina Medicare managed care programs balance a combination of benefit design, reimbursement structure, information analysis and feedback, consumer education, and active intervention that manages cost and improves quality.

Medical Groups/IPAs and delegated entities who assume responsibility for UM must adhere to Molina Medicare's UM Policies. Their programs, policies and supporting documentation are reviewed by Molina Medicare at least annually.

A. Utilization Management Goals

The goals of the UM Program at Molina Medicare are to:

- Identify medical necessity and appropriateness to ensure efficiency of the healthcare services provided;
- Continually monitor, evaluate and optimize the use of healthcare resources;
- Monitor utilization practice patterns of participating providers, hospitals and ancillary providers to identify over and under service utilization;
- Identify and assess the need for Care Management/Disease Management through early identification of high or low service utilization and high cost, chronic or long term diseases;
- Promote health care in accordance with local, state and national standards;

- Identify events and patterns of care in which outcomes may be improved through efficiencies in UM, and to implement actions that improve performance;
- Ensure timely responses to member appeals and grievances; and
- Continually seek to improve member and provider satisfaction with health care and with Molina Medicare utilization processes.
- Coordinate services between the members Medicare and Medicaid benefits when applicable.

B. Prior Authorization

Molina Medicare requires authorization for selected medical procedures, pharmaceuticals, medical equipment and services. The list of items requiring prior authorization is subject to change and so is not published here. A copy of the most recent prior authorization requirements can be found at the Molina Medicare’s website – www.molinamedicare.com – provider page -- or a written copy can be obtained by contacting the UM Department at the telephone numbers noted in the introduction to the Utilization Management chapter of this Provider Manual.

Requests for prior authorizations to the UM Department may be sent by telephone, fax, or mail based on the urgency of the requested service. Contact telephone numbers, fax numbers and addresses are noted in the introduction of this section.

Providers are encouraged to use the Molina Medicare Prior Authorization Form provided on the above web site. If using a different form, the provider is required to supply the following information, as applicable, for the requested service:

▪ Member demographic information (Name, DOB, ID #, etc.).	▪ Clinical indications necessitating service or referral.
▪ Provider information (Referring provider and referred to specialist).	▪ Pertinent medical history (include treatment, diagnostic tests, examination data).
▪ Requested service/procedure (including specific CPT/HCPCS Codes).	▪ Location where the service will be performed.
▪ Member diagnosis (ICD-9 Code and description).	▪ Requested length of stay (for inpatient requests).
▪ Indicate if request is for expedited or standard processing	▪

Molina Medicare will process requests for prior authorization and notify Members and providers of its determination using CMS approved timeframes and notification standards. A summary of the timeframes and notification standards is found in this Section, N.4., below.

Upon approval, the requestor will receive an authorization number. The number may be provided by telephone or fax. If a request is denied, the requestor and the member will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Denials also are communicated to the provider by telephone if at all possible or by fax with confirmation of receipt if telephonic communication fails.

Verbal and fax notification of denials are given within 72 hours for expedited requests and 14 days for standard requests. The written letter is mailed at the time the denial is issued.

If, after receiving a denial determination, you wish to have a peer to peer conversation or to submit additional information which may change the denial decision, proceed as follows:

- If the original turnaround time for processing the request is not passed, (14 days for standard and 72 hrs. for expedited) Molina will allow a Peer to Peer conversation. During this exchange additional information may be submitted for consideration. Additional information without a Peer to Peer conversation is not allowed. Additional information alone can be submitted when appealing a claim denial.
- Peer to Peer is available for both contract and non-contract providers
- If the decision cannot be made before the initial turnaround time expires, then the initial decision stands.

C. Affirmative Statement about Incentives

Molina Medicare requires that all medical decisions are coordinated and rendered by qualified physicians and licensed staff unhindered by fiscal or administrative concerns and ensures, through communications to providers, Members, and staff, that Molina Medicare and its delegated contractors do not use incentive arrangements to reward the restriction of medical care to Members.

Furthermore, Molina Medicare affirms that all UM decision making is based only on appropriateness of care and service and existence of coverage for its Members, and not on the cost of the service to either Molina Medicare or the delegated group. Molina Medicare does not specifically reward providers or other individuals for issuing denials of coverage or care. It is important to remember that:

- UM decision-making is based only on appropriateness of care and service and existence of coverage.
- Molina Medicare does not specifically reward providers or other individuals for issuing denials of coverage or care.
- UM decision makers do not receive incentives to encourage decisions that result in underutilization.

D. Open Communication about Treatment

Molina Medicare prohibits contracted providers from limiting provider or member communication regarding a member's health care. Providers may freely communicate with, and act as an advocate for their patients. Molina Medicare requires provisions within provider contracts that prohibit solicitation of Members for alternative coverage arrangements for the primary purpose of securing financial gain. No communication regarding treatment options may be represented or construed to expand or revise the scope of benefits under a health plan or insurance contract.

Molina Medicare and its contracted providers may not enter into contracts that interfere with any ethical responsibility or legal right of providers to discuss information with a member about the member's health care. This includes, but is not limited to, treatment options, alternative plans or other coverage arrangements.

E. Utilization Management Functions Performed Exclusively by Molina Medicare

The following UM functions are conducted by Molina Medicare (or by an entity acting on behalf of Molina Medicare) and are **never delegated**:

- 1. Transplant Case Management** - Molina Medicare does not delegate management of transplant cases to the medical group. Providers are required to notify Molina Medicare's UM Department when the need for a transplant evaluation has been identified. Contracted providers must obtain prior authorization from Molina Medicare for transplant evaluations and surgery. Upon notification, Molina Medicare conducts medical necessity review. Molina Medicare selects the facility to be accessed for the evaluation and possible transplant.
- 2. Clinical Trials** - Molina Medicare does not delegate to providers the authority to determine and authorize clinical trials. Providers are required to comply with protocols, policies, and procedures for clinical trials as set forth in Molina Medicare's contracts. For information on clinical trials, go to www.cms.hhs.gov or call **(800) MEDICARE**.

Information Only: On September 19, 2000 the Health Care Financing Administration (HCFA) approved a National Coverage Policy that permits all Medicare beneficiaries to participate in qualified clinical trials. For the initial implementation, Medicare will pay providers and hospitals directly on a fee for service basis for covered clinical trial services for Members of Molina Medicare plans and other Medicare HMO plans. The provider and/or hospital conducting the clinical trial will submit all claims for clinical trial services directly to Medicare, not to the Medicare plan. This means the member will be responsible for all Medicare fee for service deductibles and copayments for any services received as a participant in a clinical trial. I cannot confirm this is true or if it needs updating. This is still true though should be the statement and not an add on.

- 3. Experimental and Investigational Reviews** - Molina Medicare does not delegate to providers the authority to determine and authorize experimental and investigational (E & I) reviews.

F. Delegated Utilization Management Functions

Medical Groups/IPAs and delegated with UM functions must be prior approved by Molina Medicare and be in compliance with all current Molina Medicare policies. Molina Medicare may delegate UM functions to qualifying Medical Groups/IPAs and delegated entities depending on their ability to meet and maintain specific delegation criteria in compliance with all current Molina Medicare policies and regulatory and certification requirements.

Utilization management activities that may be delegated include:

- Inpatient admissions;
- Discharge Planning;
- Medical Case Management;
- Disease Management;
- Transition of Care When Benefits End;
- Organizational Determinations;
- Member Notification of Provider Termination (SNF, HHC, Free Standing Restorative Centers, PT, OT, ST);
- Emergency and Post-Stabilization Services; and/or
- Manage of Out-of-Area / Out-of-Network Admissions.

G. Prospective/Pre-Service Review

Pre-service review defines the process, qualified personnel and timeframes for accepting, evaluating and replying to prior authorization requests. Pre-service review is required for all non-emergent inpatient admissions, outpatient surgery and identified procedures, Home Health, some durable medical equipment (DME) and Out-of-Area/Out-of-Network Professional Services. The pre-service review process assures the following:

- Member eligibility;
- Member covered benefits;
- The service is not experimental or investigational in nature;
- The service meets medical necessity criteria (according to accepted, nationally-recognized resources);
- All covered services, e.g. test, procedure, are within the provider's scope of practice;
- The requested provider can provide the service in a timely manner;
- The receiving specialist(s) and/or hospital is/are provided the required medical information to evaluate a member's condition;
- The requested covered service is directed to the most appropriate contracted specialist, facility or vendor;
- The service is provided at the appropriate level of care in the appropriate facility; e.g. outpatient versus inpatient or at appropriate level of inpatient care;
- Continuity and coordination of care is maintained; and
- The PCP is kept apprised of service requests and of the service provided to the member by other providers.

H. Concurrent Review

For selected cases, Molina Medicare performs concurrent review to determine medical necessity and appropriateness of a continued inpatient stay. The goal of concurrent review is to identify appropriate discharge planning needs and facilitate discharge to an appropriate setting. CMS regulations, guidance and processes as well as evidence based criteria sets are used as guidelines in performing concurrent review activities.

The concurrent review process assures the following:

- Patients are correctly assigned to observation or inpatient status
- Services are timely and efficient;
- Comprehensive treatment plan is established;
- Member is not being discharged prematurely;
- Member is transferred to appropriate in-network hospital or alternate levels of care when clinically indicated;
- Effective discharge planning is implemented;
- Member appropriate for outpatient case management is identified and referred; and
- Decisions must be guided by CMS regulations, guidance and processes as well as evidence based criteria sets.
- Hospital readmissions are not avoidable or preventable

I. Inpatient Facility Admission

Notification of admission is required to verify eligibility, authorize care, including level of care (LOC), and initiate concurrent review and discharge planning. For emergency admissions, notification of the admission shall occur once the patient has been stabilized in the emergency department. Proper notification is required by Molina Medicare on the day of admission to ensure timely and accurate payment of hospital claims. Delegated Medical Groups/IPAs must have a clearly defined process that requires the hospital to notify Molina Medicare on a daily basis of all hospital admissions.

Notifications can be submitted by telephone or fax. Contact telephone numbers and fax numbers are noted in the introduction to the Utilization Management section of this Provider Manual.

J. Discharge Planning

Discharge planning begins on admission, and is designed for early identification of medical/ psychosocial issues that will need post-hospital intervention. The goal of discharge planning is to initiate cost-effective, quality-driven treatment interventions for post-hospital care at the earliest point in the admission. Upon discharge the provider must provide Molina with member demographic information, date of discharge, discharge plan and disposition.

Concurrent Review Nurses work closely with the hospital discharge planners to determine the most appropriate discharge setting for the patient. The concurrent review nurses review medical necessity and appropriateness for home health, infusion therapy, durable medical equipment (DME), skilled nursing facility and rehabilitative services.

K. Retrospective / Post Service Review

Retrospective Review/Post-Service Review applies when a practitioner fails to seek authorization from Molina healthcare for services that require authorization. Failure to obtain authorization for an elective service that requires authorization will result in an administrative denial. Emergent services do not require authorization. Coverage of emergent

services up to stabilization of the patient will be approved for payment. If the patient is subsequently admitted following emergent care services, authorization is required within one business day or post stabilization stay will be denied.

Failure to obtain authorization when required will result in denial of payment for those services. The only possible exception for payment as a result of post-service review is if information is received indicating the provider did not know nor reasonably could have known that patient was a Molina member or there was a Molina Healthcare error, a medical necessity review will be performed. Decisions, in this circumstance, will be based on medical need, appropriateness of care guidelines defined by UM policies and criteria, CMS Medical Coverage Guidelines, Local and National Coverage Determinations, CMS Policy Manuals, regulation and guidance and evidence based criteria sets.

Specific federal requirements or provider contracts that prohibit administrative denials supersede this policy.

L. Case Management

The Case Management Program must promote the highest quality care in the most cost-effective manner. The Case Management Program must focus on the delivery of quality, cost-effective, and appropriate healthcare services for Members with complex and chronic care needs. Proactive processes must be implemented to identify, coordinate, and evaluate appropriate high quality services which may be delivered on an ongoing basis.

To initiate the case management process, the member is screened for appropriateness for case management program enrollment using specified criteria. Criteria are used for opening and closing cases appropriately with notification to member and provider.

1. The role of the Case Manager includes:

- Coordination of quality and cost-effective services;
- Appropriate application of benefits;
- Promotion of early, intensive interventions in the least restrictive setting;
- Provision of accurate and up-to-date information to providers regarding assessment;
- Creation of individualized care plans, updated as the member's healthcare needs change;
- Utilization of multidisciplinary clinical, rehabilitative and support services;
- Arrangement of appropriate resources;
- Attention to member satisfaction;
- Attention to the handling of PHI and maintaining confidentiality;
- Provision of ongoing analysis and evaluation;
- Protection of member rights; and
- Protection of member responsibility and self-management.

2. Referral to Case Management may be made by any of the following entities:

- Member or member's designated representative;
- Member's primary care practitioner;
- Specialists;
- Hospital Staff;
- Home Health Staff; and
- Molina Medicare staff.

M. Coordination of Care

The coordination of care process assists Molina Medicare Members, as necessary, in transitioning to other care when benefits end. The process includes mechanisms for identifying Molina Medicare Members whose benefits are ending and are in need of continued care.

There are two (2) coordination of care processes for Molina Medicare Members. The first occurs when a new member enrolls in Molina and needs to transition medical care to Molina contracted providers. There are mechanisms within the enrollment process to identify those Members and reach out to them from the Member Services Department to assist in obtaining authorizations, transferring to contracted DME vendors, receiving approval for prescription medications, etc.

The second coordination of care process occurs when a Molina Medicare member's benefits will be ending and they need assistance in transitioning to other care. The process includes mechanisms for identifying Molina Medicare Members whose benefits are ending and are in need of continued care.

Providers must offer the opportunity to provide assistance to identified Members through:

- Notification of community resources, local or state funded agencies;
- Education about alternative care; and
- How to obtain care as appropriate.

N. Organization Determinations

An organization determination is any determination (e.g., an approval or denial) made by Molina Medicare or the delegated Medical Group/IPA or other delegated entity with respect to the following:

- Determination to authorize, provide or pay for services (favorable determination);
- Determination to deny requests (adverse determination);
- Discontinuation of a service;
- Payment for temporarily, out-of-the-area renal dialysis services;
- Payment for emergency services, post-stabilization care or urgently needed services; and
- Payment for any other health service furnished by a provider that the member believes is covered under Medicare or if not covered under Medicare, should have been furnished,

arranged for or reimbursed by Molina Medicare or the delegated Medical Group /IPA or other delegated entity.

All medical necessity requests for authorization determinations must be based on nationally recognized criteria that are supported by sound scientific, medical evidence. Clinical information used in making determinations include, but are not limited to, review of medical records, consultation with the treating providers, and review of nationally recognized criteria. The criteria for determining medical appropriateness must be clearly documented and include procedures for applying criteria based on the needs of individual patients and characteristics of the local delivery system.

Clinical criteria do not replace Medicare Coverage Determinations when making decisions regarding appropriate medical treatment for Molina Medicare Members. As a Medicare Plan, Molina Medicare and its delegated Medical Groups/ IPAs, or other delegated entity at a minimum, cover all services and items required by Medicare.

Requests for authorization not meeting criteria must be reviewed by a designated provider or presented to the appropriate committee for discussion and a determination. Only a provider (or pharmacist, psychiatrist, doctoral level clinical psychologist or certified addiction medicine specialist as appropriate) may determine to delay, modify or deny services to a member for reasons of medical necessity.

Board certified licensed providers from appropriate specialty areas must be utilized to assist in making determinations of medical necessity, as appropriate. All utilization decisions must be made in a timely manner to accommodate the clinical urgency of the situation, in accordance with State and Federal regulatory requirements and NCQA standards.

1. **Standard Initial Organization Determinations (Pre-service)** - Standard initial organization determinations must be made as soon as medically indicated, within a maximum of fourteen (14) calendar days after receipt of the request. The table under number four (4) below describes the CMS required decision timeframes and notification requirements followed by Molina Medicare.
2. **Expedited Initial Organization Determinations** - A request for expedited determinations may be made. An organization determination is expedited if applying the standard determination timeframes **could seriously jeopardize the life or health of the member or the member's ability to re-gain maximum function.** Molina Medicare and any delegated Medical Group/IPA or other delegated entity is responsible to appropriately log and respond to requests for expedited initial organization determinations.
 - Expedited Initial Determinations must be made as soon as medically necessary, within seventy-two (72) hours (including weekends and holidays) following receipt of the validated request; and
 - Delegated Medical Groups/IPAs and other delegated entities are responsible for submitting a monthly log of all Expedited Initial Determinations to Molina

Medicare’s Delegation Oversight Department that lists pertinent information about the expedited determination including member demographics, data and time of receipt and resolution of the issue, nature of the problem and other information deemed necessary by Molina Medicare, the Medical Group/IPA or other delegated entities. The table under number four (4) below describes the CMS required decision timeframes and notification requirements followed by Molina Medicare.

3. Written Notification of Denial - The member must be provided with written notice of the determination, if the decision is to deny, in whole or in part, the requested service or payment. If the member has an authorized representative, the representative must be sent a copy of the denial notice. The appropriate written notice, that has the Centers for Medicare and Medicaid Services (CMS) approval, must be issued within established regulatory and certification timelines. The adverse organization determination templates shall be written in a manner that is understandable to the member and shall provide the following:

- The specific reason for the denial, including the precise criteria used to make the decision that takes into account the member’s presenting medical condition, disabilities and language requirements, if any;
- Information regarding the member’s right to a standard or expedited reconsideration and the right to appoint a representative to file an appeal on the member’s behalf;
- Include a description of both the standard and expedited reconsideration process, timeframes and conditions for obtaining an expedited reconsideration, and the other elements of the appeals process;
- Payment denials shall include a description of the standard reconsideration process, timeframes and other elements of the appeal process; and
- A statement disclosing the member’s right to submit additional evidence in writing or in person.
- Failure to provide the member with timely notice of an organization determination constitutes an adverse organization determination which may be appealed.

4. Utilization Management Timeliness Standards Centers for Medicare & Medicaid Services (CMS):

Type of Request	Notification Timeframes
Standard Initial--without extension	Within 14 calendar days from receipt of the request
Standard Initial --with extension	<ul style="list-style-type: none"> • Notification of extension: Within 14 calendar days from receipt of the request • Notification of decision: • Prior to expiration of extension.

Expedited Initial Organization Determination - If Expedited Criteria are not met	<ul style="list-style-type: none"> • Notification of Expedited Criteria are not met: Within 72 hours of receipt of the request • Notification of Decision: Within 14 days of the receipt of the request (Standard request timeframe)
Expedited initial organization Determination <ul style="list-style-type: none"> • If Expedited Criteria are met 	<ul style="list-style-type: none"> • Within 72 hrs of the receipt of the request
Expedited Initial Organization Determination <ul style="list-style-type: none"> • If extension applied 	<ul style="list-style-type: none"> • Notification of Extension: Within 72 hrs of receipt of the request • Notification of decision: Prior to the expiration of the extension

- 5. Termination of Provider Services (SNF, HH, CORF)/Issuance of Notice of Medicare Non-Coverage (NOMNC) and Detailed Explanation of Non-Coverage (DENC) -** When a termination of authorized coverage of a member’s admission to a skilled nursing facility (SNF) or coverage of home health agencies (HHA) or comprehensive outpatient rehabilitation facility (CORF) services occurs, the member must receive a written notice two (2) calendar days or two (2) visits prior to the proposed termination of services.

Molina Medicare or the delegated Medical Group/IPA must coordinate with the SNF, HHA or CORF provider to ensure timely delivery of the written notice, using the approved Notice of Medicare Non-Coverage (NOMNC). Delivery of the notice is not valid unless all elements are present and member or authorized representative signs and dates the notice to document receipt.

- The NOMNC must include the member’s name, delivery date, date that coverage of services ends and QIO information;
- The NOMNC may be delivered earlier than two (2) days before coverage ends;
- If coverage is expected to be fewer than two (2) days in duration, the NOMNC must be provided at the time of admission; and
- If home health services are provided for a period of time exceeding two (2) days, the NOMNC must be provided on or before the second to last service date.

Molina Medicare (or the delegated entity) remains liable for continued services until two (2) days after the member receives valid notice. If the member does not agree that covered services should end, the member may request a Fast Track Appeal by the Quality

Improvement Organization (QIO) by noon of the day following receipt of the NOMNC, or by noon of the day before coverage ends.

Upon notification of the member's request for the Fast Track Appeal, Molina Medicare (or the delegated entity) must provide a detailed notice to the member and to the QIO no later than the close of business, using the approved Detailed Explanation of Non-Coverage (DENC) explaining why services are no longer necessary or covered. The DENC must include the following:

- A specific and detailed explanation why services are either no longer reasonable and necessary or otherwise no longer covered;
- A description of any applicable coverage rule, instruction or other policy, citations, or information about how the member may obtain a copy of the policy from Molina Medicare or the delegated entity;
- Any applicable policy, contract provision or rationale upon which the termination decision was based; and
- Facts specific to the member and relevant to the coverage determination that is sufficient to advise the member of the applicability of the coverage rule or policy to the member's case.

O. Continuity of Care

Molina Medicare and its contracted providers must provide continued services to Members undergoing a course of treatment by a provider that has terminated their contractual agreement if the following conditions exist at the time of termination:

- **Acute condition or serious chronic condition** - Following termination, the terminated provider will continue to provide covered services to the member up to ninety (90) days or longer if necessary for a safe transfer to another provider as determined by Molina Medicare or its delegated Medical Group/IPA.
- **High risk of second or third trimester pregnancy** - The terminated provider will continue to provide services following termination until postpartum services related to delivery are completed or longer if necessary for a safe transfer.

P. Emergency and Post-Stabilization Services

Molina Medicare and its contracted providers must provide emergency services and post-emergency stabilization and maintenance services to treat any member with an Emergency Medical Condition in compliance with federal and state law. An Emergency Medical Condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the member including the health of a pregnant woman and/or her unborn child in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any body part; and/or
- Serious disfigurement.

Molina Medicare covers maintenance care and post-stabilization services which are medically necessary, non-emergency services. Molina Medicare or its delegated entity arranges for post-stabilization services to ensure that the patient remains stabilized from the time the treating hospital requests authorization until the time the patient is discharged or a contracting medical provider agrees to other arrangements.

Pre-approval of emergency services is not required. Molina Medicare requires the hospital emergency room to contact the member's primary care practitioner upon the member's arrival at the emergency room. After stabilization of the member, Molina Medicare requires pre-approval of further post-stabilization services by a participating provider or other Molina Medicare representative. Failure to review and render a decision on the post-stabilization pre-approval request within one (1) hour of receipt of the call shall be deemed an authorization of the request.

Molina Medicare or its delegated entity is financially responsible for these services until Molina Medicare or its delegated entity becomes involved with managing or directing the member's care

Molina Medicare and its delegated entity provides urgently needed services for Members temporarily outside of the service area but within the United States or who have moved to another service area but are still enrolled with Molina Medicare. Urgent Services are covered services that are medically necessary and are needed urgently, typically the same day or within two (2) days of onset of symptoms, as judged by a prudent layperson.

Q. Delegation Oversight of Providers Performing UM Functions

Molina Medicare provides oversight and ongoing evaluation of those Medical Groups/IPAs and entities delegated to perform UM functions. The Delegation Oversight staff is responsible for systematic monitoring of each delegated Medical Group/IPA and entity to ensure their continued ability to perform the delegated activities. At least annually, the Delegation Oversight staff conducts an audit of each delegated entity to ensure compliance with Molina Medicare's delegation requirements as well as adherence to all applicable regulatory and accreditation standards. A specifically designed UM audit tool is utilized for this assessment and evaluation.

- 1. Initial Approval for Delegation** - In order to receive delegation status for UM activities, provider groups and other entities must demonstrate compliance with Molina Medicare's established UM standards. Delegation of selected functions may occur only after an initial audit of the utilization activities has been completed and there is evidence that

Molina Medicare's delegation requirements are met. Findings are presented to Molina Committees for approval and granting of delegation status.

A mutually agreed upon written delegation agreement describing the responsibilities of Molina Medicare and the delegated entities will be maintained and reviewed annually. The delegation agreement includes a written description of the specific utilization delegated activities, monitoring of delegated functions, and corrective action or termination of delegated entities that fail to adequately perform delegated functions.

2. **Criteria for Delegated Utilization Management** - Molina Medicare requires that delegated entity have a written Utilization Management Program in place which includes a detailed description of the UM program operations. The program must have documented goals and objectives, and describe the organizational structure and staffing for performing the program functions. The UM program must be approved by the delegated entity's Utilization Management Committee and/or governing board annually, and documentation of the review and approval must be submitted to Molina Medicare. Nationally recognized UM criteria must be included in the program to ensure consistent decision making during the review process.

Compliance with Molina Medicare's Utilization Management Program requires delegated Medical Group/IPA and delegated entities to meet standards that include, but are not limited to the following:

- Timely, complete and accurate response to Molina Medicare's request for information regarding Utilization Management activities;
- Compliance with Molina Medicare's requirements for determining and authorizing level of care for every patient every day;
- Active communication (daily or as requested based on the clinical condition of the member) with Molina staff to ensure accurate recording of authorized level of care;
- Active collaboration and coordination with Molina Medicare's UM staff performing concurrent review, case management and discharge planning;
- Compliance with all Molina Medicare's data submission and reporting requirements;
- Maintenance of accurate, timely and consistently formatted medical records as requested; and
- Providers shall educate and train hospital staff and provide sufficient oversight to ensure their compliance with Molina Medicare's UM Program requirements as they relate to prior authorization, concurrent review and discharge planning for hospitalized Members.

The delegated provider must have an established Utilization Management Committee which meets at least quarterly to review utilization issues and determine improvement plans where indicated. Molina Medicare representatives may attend the committee meeting, with advance notice. Minutes of the Utilization Management Committee must be made available to Molina Medicare upon request. Molina Medicare Delegation Oversight staff must be permitted reasonable access to the UM files, minutes and records of the provider entity for the purpose of auditing UM activities.

Delegated entities are required to provide evidence that internal procedures are operational and to take appropriate action in areas where problems are identified. These entities are responsible for providing feedback to Molina Medicare regarding the conclusions, recommendations, actions and follow-up where problems have been identified.

R. Reporting of Suspected Abuse of an Adult

A vulnerable adult is a person who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation.

Molina Medicare reports suspected or potential abuse of vulnerable adults as required by state and federal law. A vulnerable adult is defined as a person who is not able to defend themselves, protect themselves, or get help for themselves when injured or emotionally abused. A person may be vulnerable because of a physical condition or illness (such as weakness in an older adult or physical disability) or a mental/behavioral or emotional condition. Mandatory reporters include:

- Molina Medicare employees who have knowledge of the abuse;
- Law enforcement officer;
- Social worker; professional school personnel; individual provider; an employee of a facility; an operator of a facility; and/or
- An employee of a social service, welfare, mental /behavioral health, adult day health, adult day care, home health, home care, or hospice agency; county coroner or medical examiner; Christian Science Provider or healthcare provider.

A permissive reporter is any individual with knowledge of a potential abuse situation who is not included in the list of mandatory reporters. A permissive reporter may report to the Molina UM Department or a law enforcement agency when there is reasonable cause to believe that a vulnerable adult is being or has been abandoned, abused, financially exploited or neglected. Permissive or voluntary reporting will occur as needed.

The following are the types of abuse which are required to be reported:

- **Physical abuse** is intentional bodily injury. Some examples include slapping, pinching, choking, kicking, shoving, or inappropriately using drugs or physical restraints.
- **Sexual abuse** is nonconsensual sexual contact. Examples include unwanted touching, rape, sodomy, coerced nudity, sexually explicit photographing.
- **Mental/behavioral mistreatment** is deliberately causing mental or emotional pain. Examples include intimidation, coercion, ridiculing; harassment; treating an adult like a child; isolating an adult from family, friends, or regular activity; use of silence to control behavior; and yelling or swearing which results in mental distress.
- **Neglect** occurs when someone, either through action or inaction, deprives a vulnerable adult of care necessary to maintain physical or mental health.

- **Self-neglect** occurs when a vulnerable adult fails to provide adequately for themselves. A competent person who decides to live their life in a manner which may threaten their safety or well-being does not come under this definition.
- **Exploitation** occurs when a vulnerable adult or the resources or income of a vulnerable adult are illegally or improperly used for another person's profit or gain.
- **Abandonment** occurs when a vulnerable adult is left without the ability to obtain necessary food, clothing, shelter or health care.

In the event that an employee of Molina Medicare or one of its contracted providers encounters potential or suspected abuse as described above, a call must be made to:

County Department of Job and Family Services

- Butler County: (513) 887-4000 or toll free (800) 582-4267
- Clark County: (937) 327-1700 or toll free (800) 516-3463
- Clermont County: (513) 732-7111
- Delaware County: (740) 833-2300 or toll free (800) 899-3180
- Franklin County: (614) 462-4000
- Greene County: (937) 562-6000 or toll free (800) 361-4450
- Hamilton County: (513) 946-1000
- Madison County: (740) 852-4770 or toll free (800) 852-0243
- Miami County: (937) 440-3471
- Montgomery County: (937) 496-6654
- Morrow County: (419) 947-9111 or toll free (800) 668-6458
- Pickaway County: (740) 474-7588 or toll free (800) 822-5437
- Preble County: (937) 456-6205
- Union County: (937) 644-1010 or toll free (800) 248-2347
- Warren County: (513) 695-1420

All reports should include:

- Date abuse occurred;
- Type of abuse;
- Names of persons involved if known;
- Source of Information;
- Names and telephone numbers of other people who can provide information about the situation; and
- Any safety concerns.

Molina Medicare's Care Integration Team (CIT) will work with PCPs and Medical Groups/IPA and other delegated entities who are obligated to communicate with each other when there is a concern that a member is being abused. Final actions are taken by the PCP/Medical Group/IPA, other delegated entity or other clinical personnel. Under state law, a person participating in good faith in making a report or testifying about alleged abuse, neglect, abandonment, financial exploitation or self-neglect of a vulnerable adult in a judicial or administrative proceeding may be immune from liability resulting from the report or testimony.

Molina Medicare will follow up with Members that are reported to have been abused to ensure appropriate measures were taken, and follow up on safety issues. Molina Medicare will track, analyze, and report aggregate information regarding abuse reporting to the Utilization Management Committee and the proper state agency.

S. Primary Care Practitioners

Molina Medicare provides a panel of primary care practitioners (PCPs) to care for its Members. Providers in the specialties of Family Medicine, Internal Medicine and Obstetrics and Gynecology are eligible to serve as PCPs. Members may choose a PCP or have one selected for them by Molina. Molina Medicare Members are required to see a PCP who is part of the Molina Medicare Network. Molina Medicare Members may select or change their PCP by contacting the Molina Member Services Department.

T. Specialty Providers

Molina Medicare maintains a network of specialty providers to care for its Members. Referrals from a Molina Medicare PCP are required for a member to receive specialty services, however, no prior authorization is required. Members are allowed to directly access women health specialists for routine and preventive health without a referral services.

Molina Medicare will help to arrange specialty care outside the network when providers are unavailable or the network is inadequate to meet a member's medical needs. To obtain such assistance contact the Molina Medicare UM Department. Referrals to specialty care outside the network require prior authorization from Molina Medicare.

U. Molina Medicare Special Needs Plan Model of Care

- 1. Targeted Population** - Molina Medicare operates Medicare Dual Eligible Special Needs Plans (SNP) for Members who are eligible for both Medicare and Medicaid. In accordance with the Centers for Medicare and Medicaid Services (CMS) regulations, Molina Medicare has a SNP Model of Care that outlines Molina's efforts to meet the needs of the dual eligible SNP population. This population has a higher burden of multiple chronic illnesses and sub-populations of frail/disabled Members than other Medicare Managed Care Plan types. The Molina Dual Eligible Special Needs Plan Model of Care addresses the needs of all sub-populations found in the Molina Medicare SNP.
- 2. Care Management Goals** - Utilization of the Molina Medicare SNP extensive network of primary providers, specialty providers and facilities, in addition to services from the Molina Medicare SNP Interdisciplinary Care Team (ICT), will improve access of Molina Members to essential services such as medical, mental health and social services. Molina demonstrates its compliance with this goal using the following data and comparing against available internal and external benchmarks and expects to see annual improvement compared to benchmarks:

- a. Molina Medicare Geo Access reports showing availability of services by geographic area;
- b. Number of Molina SNP Members utilizing the following services:
 - Primary care practitioner (PCP) Services
 - Specialty (including Mental/Behavioral Health) Services
 - Inpatient Hospital Services
 - Skilled Nursing Facility Services
 - Home Health Services
 - Mental/Behavioral Health Facility Services
 - Durable Medical Equipment Services
 - Emergency Department Services
 - Supplemental transportation benefits
- c. Healthcare Effectiveness Data and Information Set (HEDIS) use of services reports;
- d. Member Access Complaint Report;
- e. Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey; and
- f. Molina Medicare Provider Access Survey.

http://www.molinamedicare.com/en-us/providers/pages/provider_splash.aspx?E=true

3. Members of the Molina Medicare SNP will have access to quality affordable healthcare. Since Members of the Molina Medicare SNP are dual eligible for Medicare and Medicaid they are not subject to out of pocket costs or cost sharing for covered services. Molina focuses on delivering high quality care. Molina has an extensive process for credentialing network providers, ongoing monitoring of network providers and peer review for quality of care complaints. Molina maintains recommended clinical practice guidelines that are evidence based and nationally recognized. Molina regularly measures provider adherence to key provisions of its clinical practice guidelines. Molina demonstrates its compliance with this goal using the following data and comparing against available internal and external benchmarks and expects to see annual improvement compared to benchmarks:

- a. HEDIS report of percent providers maintaining board certification;
- b. Serious reportable adverse events report;
- c. Annual report on quality of care complaints and peer reviews;
- d. Annual PCP medical record review;

- e. Clinical Practice Guideline Measurement Report;
 - f. Licensure sanction report review; and
 - g. Medicare/Medicaid sanctions report review.
4. By having access to Molina’s network of primary care and specialty providers as well as Molina’s programs in Care Management Programs including Case Management, Disease Management, Care Coordination, Nurse Advice Line, Utilization Management and Quality Improvement, **SNP Members have an opportunity to realize improved health outcomes.**

Molina demonstrates its compliance with this goal using the following data and comparing against available internal and external benchmarks and expects to see annual improvement compared to benchmarks:

- a. Medicare Health Outcomes Survey (HOS); and
 - b. Chronic Care Improvement Program Reports.
5. **Molina Members will have an assigned point of contact for their coordination of care.** According to member need this coordination of care contact point might be their Molina Network PCP, Molina Care Manager or Molina Case Manager. Care will be coordinated through a single point of contact with Members for the Molina Interdisciplinary Care Team (ICT) interacting with the single point of contact person to coordinate care as needed.
6. **Members of the Molina Medicare SNP will have improved transitions of care across healthcare settings, providers and health services.** The Molina SNP has multiple programs designed to improve transitions of care. Authorization processes enable Molina staff to become aware of transitions of care due to changes in healthcare status as they occur. Molina care managers and case manager’s work with Members, their caregivers and their providers to assist in care transitions. In addition Molina has a program to provide follow-up telephone calls or face to face visits to Members after hospital discharge to make sure that they received and are following an adequate discharge plan. The purpose is to evaluate if the member is following the prescribed discharge plan, has scheduled a follow up physician appointment, has filled all prescriptions, understands how to administer their medications and is receiving necessary discharge services such as home care or physical therapy. All Members experiencing transitions receive a post discharge educational letter advising them of benefits and services offered by Molina. Molina demonstrates its compliance with this goal using the following data and comparing against available internal and external benchmarks and expects to see annual improvement compared to benchmarks:
- a. Transition of Care Data;

- b. Re-admission within 30 Days Report;
- c. Provider adherence to notification requirements; and
- d. Provider adherence to provision of the discharge plan.

7. Members of the Molina Medicare SNP will have improved access to preventive health services. The Molina SNP expands the Medicare preventive health benefit by providing annual preventive care visits at no cost to all Members. This allows PCPs to coordinate preventive care on a regular basis. Molina uses and publicizes nationally recognized preventive health schedules to its providers. Molina also makes outreach calls to Members to remind them of overdue preventive services and to offer assistance with arranging appointments and providing transportation to preventive care appointments.

Molina demonstrates its compliance with this goal using the following data and comparing against available internal and external benchmarks and expects to see annual improvement compared to benchmarks: HEDIS Preventive Services Reports

8. Members of Molina Medicare SNP will have appropriate utilization of healthcare services. Molina utilizes its Utilization Management team to review appropriateness of requests for healthcare services using appropriate Medicare criteria and to assist in Members receiving appropriate healthcare services in a timely fashion from the proper provider.

Molina demonstrates its compliance with this goal using the following data and comparing against available internal and external benchmarks and expects to see annual improvement compared to benchmarks: Molina Over and Under Utilization Reports.

9. Staff Structure and Roles - The Molina Medicare SNP has developed its staff structure and roles to meet the needs of dual eligible Special Needs Plan Members. Molina's background as a provider of Medicaid Managed Care services in the states that it serves allows the plan to have expertise in both the Medicare and Medicaid benefits that Members have access to in the Molina Medicare Dual Eligible SNP. Molina has many years experience managing this population of patients within Medicaid to go with its experience of managing the Medicare part of their benefit. Molina Medicare's member advocacy and service philosophy is designed and administered to assure Members receive value-added coordination of health care and services that ensures continuity and efficiency and that produces optimal outcomes. Molina Medicare employed staff are organized in a manner to meet this objective and include:

a. Care Management Team that forms a main component of the interdisciplinary care team (ICT) comprised of the following positions and roles:

- i. Utilization Management Coordinator – Gather clinical information about transitions in care and authorizations for services, authorize services within their scope of training and job parameters based upon predetermined criteria, serve as a

resource for nursing staff in collecting existing clinical information to assist nursing assessments and care team coordination.

- ii. Utilization Management Specialists (LPN/LVN) – Assess, authorize, coordinate and evaluate services in conjunction with the member, providers and other team members based on member’s needs, medical necessity and predetermined criteria.
 - iii. Licensed Clinical Social Workers – Address issues regarding member’s mental/behavioral health care and social needs and care plans. Assist in coordination and transitions of care involving mental/behavioral health and social services. Assist member in accessing community and social service resources.
 - iv. Clinical Case Managers (RN) – assess, authorize, coordinate and evaluate services in conjunction with the member, providers and other team Members based on member’s needs, medical necessity and predetermined criteria. Assist Members, caregivers and providers in member transitions between care settings. Develop, implement, monitor and evaluate care plans in conjunction with Members/caregivers, their providers and other team Members for Members not requiring case management.
 - v. Complex Case Managers (RN) – Assesses and manage member’s medical, psychosocial, physical and spiritual needs – develop, implement, monitor and evaluate care plans in conjunction with Members/caregivers, their providers and other team Members. Focus is on Members with complex medical illness.
 - vi. Care Coordinators (RN, SW) – Identify care needs through ongoing clinical assessments of Members identified as high risk or having complex needs. Activities include coordinating services of medical and non-medical care along a continuum rather than episodic care focused on a member’s physical health care, mental/behavioral health care, chemical dependency services, long term care, and social support needs while creating individualized care plans.
 - vii. Health Educator-Certified staff to provide disease specific education and behavior change support, e.g. smoking cessation or weight management to Medicare SNP members.
- b. Member Services Team** that serves as a member’s initial point of contact with Molina Medicare and main source of information about utilizing the Molina Medicare SNP benefits and is comprised of the following positions:
- i. Member Services Representative – Initial point of contact to answer member questions, assist with benefit information and interpretation, act as liaison in directing calls to other departments when necessary to assist Members.
 - ii. Member Services Managers/Directors – Provide oversight for member services programs, provide and interpret reporting on member services functions, evaluate member services department functions, identify and address opportunities for improvement.
- c. Appeals and Grievances Team** that assists Members with information about and processing of appeals and grievances:

- i. Appeals and Grievances Coordinator – Provide member with information about appeal and grievance processes, assist Members in processing appeals and grievances, notifies Members of appeals and grievance outcomes in compliance with CMS regulations.
 - ii. Appeals and Grievances Manager – Provide oversight of appeals and grievance processes assuring that CMS regulations are followed, provide and interpret reporting on A&G functions, evaluate A&G department functions, identify and address opportunities for improvement.
- d. Quality Improvement Team** that develops, monitors, evaluates and improves the Molina Medicare SNP Quality Improvement Program. QI Team is comprised of the following positions:
- i. QI Specialist – Coordinate implementation of QI Program, gather information for QI Program reporting and evaluations, provide analysis of QI Program components.
 - ii. QI Managers/Directors – Development and oversight of QI Program and credentialing program, provide and interpret reporting on QI Program, evaluate QI Program, and identify and address opportunities for improvement.
 - iii. HEDIS Specialist – Gather and validate data for HEDIS reporting.
 - iv. HEDIS Manager – Oversight and coordination of data gathering and validation for HEDIS reporting, provide and interpret HEDIS reports, provide preventive services missing services report.
 - v. Credentialing Specialist – Gather data and reporting for credentialing function.

Role of the Chief Medical Officer (CMO), Medical Director and Associate Medical Director:

The CMOs holds a current, unrestricted physician license and report to the Plan Presidents and CEO. Responsibilities include, but are not limited to:

- Represent the ICS Program throughout the organization and report to the Molina Healthcare State Plan Boards of Directors and the Plan President
- Chair the UMC
- Lead role in the evaluation of new technology
- Evaluate satisfaction with the ICS Program on an annual basis and ensure corrective actions
- Liaison with Provider Services
- Authority, responsibility and accountability for denial determinations when acting as a clinical reviewer
- Evaluate Inter-Rater Reliability of physician reviewers.

The Medical Director/Associate Medical Director holds a current, unrestricted license and reports to the CMO. Responsibilities include, but are not limited to:

- Participates as a member of the Interdisciplinary Care Team
- Participates in the implementation of ICS Department Program.

- May chair UMC and Clinical Quality Management Committee for development, approval and/or adoption of clinical decision criteria.
 - Participates on the Molina Healthcare Inc Medical Coverage Guidance Committee.
 - Conducts UM/CM reviews and conducts clinical discussion with physicians.
 - Holds the authority, accountability and responsibility for denial determinations for lack of medical necessity.
 - Consults with the board certified specialists of the specialty panel for review of behavioral health and other complex utilization issues.
 - Serve as consultant to UM/CM personnel
 - Actively participate in staff development
 - Participate in individual case review
 - Authority, responsibility and accountability for denial determinations
 - Serve as a peer reviewer to practitioners to discuss potential denials.
- e. Mental/Behavioral Health Team** has Molina employed health specialists to assist in mental/behavioral health care issues:
- i.** Psychologists – Resource for Care Management Teams and providers regarding member’s mental/behavioral health care needs and care plans.
 - ii.** Psychiatrist Medical Director – Responsible for oversight of the development and integrity of mental/behavioral health aspects of Molina Medicare SNP Utilization Management and Quality Improvement programs. Resource for Care Management Teams and providers regarding member’s mental/behavioral health care needs and care plans. Develops and monitors usage of mental/behavioral health related medical necessity criteria and clinical practice guidelines.
- g. Pharmacy Team** has employed pharmacy professionals that administer the Part D benefit and assist in administration of Part B pharmacy benefits.
- i.** Pharmacy Technician – Provide authorizations for Part D medications, serves as point of contact for Members with questions about medications, pharmacy processes, and pharmacy appeals and grievances.
 - ii.** Pharmacist – Provide oversight of pharmacy technician performance, resource for Care Management Teams, other Molina staff and providers, provide review of post discharge medication changes, review member medication lists and report data to assure adherence and safety, interact with Members and providers to discuss medication lists and adherence.
- h. Healthcare Analytics Team**
- i.** Healthcare Analysts – Assist in gathering information, developing reports, providing analysis for health plan to meet CMS reporting requirements, evaluate the model of care and review operations
 - ii.** Director Healthcare Analytics – Develop predictive modeling programs used to assist in identifying Members at risk for future utilization, oversight of healthcare

reporting and analysis program, oversight of clinical aspects of Part C Quality Reporting, oversight of healthcare analysts.

i. Health Management Team is a Molina care team that provides multiple services to Molina Medicare SNP Members. This team provides population based Disease Management Programs in asthma, diabetes, COPD and cardiovascular diseases. CPS also provides a 24/7 Nurse Advice Line for Members, outbound post hospital discharge calls and outbound preventive services reminder calls. The CPS team is comprised of the following positions:

- i.** Medicare member Outreach Assistant – Make outbound calls related to gathering and giving information regarding Disease Management programs, make outbound calls to review whether member received hospital discharge plan, make referrals to Care/Case Managers when Members have questions about their hospital discharge plan, make outbound preventive service reminder calls.
 - ii.** Nurse Advice Line Nurse – Receive inbound calls from Members and providers with questions about medical care and after-hours issues that need to be addressed, give protocol based medical advice to Members, direct after hours transitions in care.
 - iii.** Health Educator – Develop materials for Disease Management Programs, serve as resource for Members and Molina staff Members regarding Disease Management Program information, educates Members on how to manage their condition.
 - iv.** Disease Management Nurse – Oversight for development and implementation of Disease Management Programs, resource for providers and staff Members with questions or concerns about Disease Management Programs. Provides ongoing contact with Members to educate on their condition(s) and self-management techniques, screens high risk Members and refers to case management as appropriate.
- j. Interdisciplinary Care Team** - The Molina Medicare SNP Interdisciplinary Care Team is the core of Molina’s Care Management Program. The ICT is typically composed of the member’s assigned PCP and the Molina Care Management Team (Authorization Coordinator, Licensed Clinical Social Worker, Care Manager, Case Manager).

The composition of this team is designed to address all aspects of a member’s healthcare needs, including medical, mental/behavioral and social health. Additional Members of the ICT may be added on a case-by-case basis depending on a member’s conditions and health status.

- Additional positions who may be included (either temporarily or permanently) to the Molina Medicare SNP ICT caring for Members that may included: Molina Medical Directors
- Molina Mental/Behavioral Health Specialists
- Molina Pharmacists
- Network Medical Specialty Providers

- Network Home Health Providers
- Network Acute Care Hospital Staff
- Network Skilled Nursing Facility Staff
- Network Long Term Acute Care Facility Staff
- Network Certified Outpatient Rehabilitation Staff
- Network Mental/Behavioral Health Facility Staff
- Network Renal Dialysis Center Staff
- Out of Network Providers or Facility Staff (until a member's condition of the state of the Molina Network allows safe transfer to network care)
- Adding Members to the ICT will be considered when member:
 - has been stratified to a catastrophic or high risk group in the assessment process.
 - is undergoing a transition in healthcare setting.
 - sees multiple medical specialists for care on a regular and ongoing basis.
 - has significant complex or unresolved medical diagnoses.
 - has significant complex or unresolved mental/behavioral health diagnoses.
 - has significant complex or unresolved pharmacy needs.
- Molina Medicare SNP Members and their caregivers participate in the Molina ICT through many mechanisms including:
 - Discussions about their health care with their PCP.
 - Discussions about their health care with medical specialists or ancillary providers who are participating in the member's care as directed by the member's PCP.
 - Discussions about their health care with facility staff who are participating in the member's care as directed by the member's PCP.
 - During the assessment process by Molina Staff.
 - Discussions about their health care with their assigned Molina Care Management Team Members.
 - Discussions with Molina Staff in the course of disease management programs, preventive healthcare outreach and post hospital discharge outreach.
 - Discussion with Molina Pharmacists about complex medication issues.
 - Through the appeals and grievance processes.
 - By invitation during case conferences or regular ICT meetings.
 - By request of the member or caregiver to participate in regular ICT meetings.

The Molina Medicare SNP member's assigned PCP and the Molina Care Management Team will provide the majority of the care management in the ICT. The member's assigned PCP will be a primary source of assessment information, care plan development and member interaction within the ICT. The PCP will regularly (frequency depends on the member's medical conditions and status) assess the member's medical conditions, develop appropriate care plans, request consultations, evaluations and care from other providers both within and when necessary outside the

Molina Network. The Molina Care Management Team will also provide assessments, care plan development and individualized care goals.

The Care Management Team will be primarily involved during assessment periods, during transitions of care settings, during routine case management follow-up, after referral from other Molina Staff (e.g., Disease Management Program staff, Pharmacists), requests for assistance from PCPs and requests for assistance from Members/caregivers and during significant changes in the member's health status. Transitions in care and significant changes in health status, that need follow-up, will be detected when services requiring prior authorization are requested by the member's PCP (signaling a transition in care or complex medical condition or need).

The PCP and Care Management Team will decide when additional ICT Members are necessary and invite their participation on an as needed basis as previously documented. Communication between ICT Members will be compliant with all applicable HIPAA regulations and will occur in multiple ways including:

- Care Management Team to acquire and review member's medical records from providers on the ICT before, during and after transitions in care and during significant changes in the health status of Members.
- Care Management Team to acquire and review member's medical records from provider Members of the ICT during authorization process for those medical services that require prior authorization.
- Care Management Team to acquire and review member's medical records from provider Members of the ICT during the course of regular case management activities.
- Verbal or written communication between PCP and Care Management Team may occur during PCP participation in regular Care Management Team meetings on an as needed basis.
- Written copies of assessment documents from Care Management Team to PCP by request and on an as needed basis.
- Written copies of individualized care plan from Care Management Team to PCP (and other providers as needed).
- Member assessment and lab data from in-home assessment vendors

Documentation of the activities of the ICT will occur in three primary places: the PCP medical record, Molina's QNXT Information Technology Platform and Molina's Clinical Care Advance Care/Case Management/Disease Management Platform. The PCP medical record will be used to document PCP assessments, care plans, information related to care transitions (hospital discharge summaries, SNF notes, home health notes), specialty consultations, laboratory testing reports and imaging reports, communications with the Molina Care Management Team. The Molina QNXT Platform will be used to document member demographics and eligibility, claims activities, call tracking of conversations with providers/Members/caregivers, call tracking of grievances, authorizations for services, preventive services reminder

flags, care management interactions and clinical notes regarding medical services and care transitions.

The Molina Clinical Care Advance Platform will be used to document member specific information on assessments, individualized care plans, automated reminders for the Care Management Team, care/case management interventions, care/case management interactions with providers and Members/caregivers, Disease Management Program participation and interventions.

10. Provider Network - The Molina Medicare SNP maintains a network of providers and facilities that has a special expertise in the care of Dual Eligible Special Needs Plans Members. The population served in Dual Eligible Special Needs Plans has a disproportionate share of physical and mental/behavioral health disabilities. Molina's network is designed to provide access to medical care for the Molina Medicare SNP population.

The Molina Medicare SNP Network has facilities with special expertise to care for its SNP Members including:

- Acute Care Hospitals
- Long Term Acute Care Facilities
- Skilled Nursing Facilities
- Rehabilitation Facilities (Outpatient and Inpatient)
- Mental/Behavioral Health/Substance Abuse Inpatient Facilities
- Mental/Behavioral Health/Substance Abuse Outpatient Facilities
- Outpatient Surgery Centers (Hospital-based and Freestanding)
- Laboratory Facilities (Hospital-based and Freestanding)
- Radiology Imaging Centers (Hospital-based and Freestanding)
- Renal Dialysis Centers
- Emergency Departments (Hospital-based)
- Urgent Care Centers (Hospital-based and Freestanding)
- Diabetes Education Centers (Hospital-based)

The Molina Medicare SNP has a large community based network of medical and ancillary providers with many having special expertise to care for the unique needs of its SNP Members including:

- Primary Care Practitioners – Internal Medicine, Family Medicine, Geriatric
- Medical Specialists (all medical specialties) including specifically Orthopedics, Neurology, Physical Medicine and Rehabilitation, Cardiology, Gastroenterology, Pulmonology, Nephrology, Rheumatology, Radiology and General Surgery.
- Mental/Behavioral Health Providers – Psychiatry, clinical psychology, Masters or above level licensed clinical social work, certified substance abuse specialist.
- Ancillary Providers – Physical therapists, occupational therapists, speech/ language pathology, chiropractic, podiatry.
- Nursing professionals – Registered nurses, nurse providers, nurse educators.

Molina determines provider and facility licensure and competence through the credentialing process. Molina has a rigorous credentialing process for all providers and facilities that must be passed in order to join the Molina Medicare SNP Network. The Molina Credentialing Team gathers information and performs primary source verification (when appropriate) of training, active licensure, board certification, appropriate facility accreditation (JCAHO or state), malpractice coverage, malpractice history (National Practitioner Data Bank reports), Medicare opt out status, Medicare/Medicaid sanctions, state licensure sanctions.

After credentialing information file is complete and primary source verification obtained the provider or facility is presented to the Molina Professional Review Committee (PRC). The PRC consists of Molina Network physicians who are in active practice as well as Molina Medical Directors. The PRC decides on granting network participation status to providers who have gone through the credentialing process based on criteria including active licensure, board certification (may be waived to assure member access when there is geographic need or access problems), freedom from sanctions and freedom from an excessive malpractice case history. Providers and facilities that have passed initial credentialing must go through a re-credentialing process every three (3) years utilizing the same criteria as the initial credentialing process. In addition the PRC performs ongoing monitoring for licensure status, sanctions, Medicare opt out status, member complaint reports and peer review actions on a monthly basis (or quarterly for some reporting).

The member's PCP is primarily responsible for determining what medical services a member needs. For Members receiving treatment primarily through specialist physician, the specialist may be primarily responsible for determining needed medical services. The PCP is assisted by the Molina Care Management Team, medical specialty consultants, ancillary providers, mental/behavioral health providers and Members or their caregivers in making these determinations. For Members undergoing transitions in healthcare settings, facility staff (hospital, SNF, home health, etc.) may also be involved in making recommendations or assisting with access to needed services. For those services that require prior authorization the Molina Care Management Team will assist providers and Members in determining medical necessity, available network resources (and out of network resources where necessary). The Molina Care Management portion of the ICT will assist in finding access when difficulties arise for certain services.

A primary way that the Molina Provider Network coordinates with the ICT is via the Molina Medicare SNP Prior Authorization process. Molina Medicare SNP Prior Authorization requirements have been designed to identify Members who are experiencing transitions in healthcare settings or have complex or unresolved healthcare needs. Molina Members undergoing transitions in healthcare settings or experiencing complex or unresolved healthcare issues usually require services that are prior authorized. This allows Members of the ICT to be made aware of the need for services and any changes in the member's health status. Part of the process includes obtaining medical records and documenting in QNXT so that the ICT can track those changes. The

provider network will also communicate with the ICT when invited to attend ICT meetings, on an as needed basis by contacting the PCP or the Molina Care Management Team. Molina's electronic fax system allows for the transition of information from one provider to another during transitions. Hospital inpatient information is provided to the PCP and/or treating provider.

The Molina Medicare SNP will assure that specialized services are delivered in a timely and quality way by the following:

- Assuring that services requiring prior authorization are processed and that notification is sent as soon as required by the member's health but no later than timelines outlined in CMS regulations.
- Directing care to credentialed network providers when appropriate.
- Monitoring access to care reports and grievance reports regarding timely or quality care.

Reports on services delivered will be maintained by the ICT primarily in the PCP medical record. The Molina Medicare SNP regularly audits the completeness of PCP medical records utilizing the annual PCP Medical Record Review process. The Molina Care Management Team will document relevant clinical notes on services and outcomes in QNXT and Clinical Care Advance platforms as appropriate to document significant changes in the member's healthcare status or healthcare setting and to update care plans. A copy of the care plan will be provided to the PCP.

The Molina Medicare SNP ICT will be responsible for coordinating service delivery across care settings and providers. The member's assigned PCP will be responsible for initiating most transitions of care settings (e.g., hospital or SNF admissions) and referrals to specialty or ancillary providers. The Molina Care Management Team will assist specifically with Prior Authorization, access issues and coordinating movement from one care setting to the next when Members experience a change in their health care status (e.g., hospital discharge planning).

The Molina Medicare SNP will use nationally recognized, evidence based clinical practice guidelines. Molina Medical Directors will select clinical practice guidelines that are relevant to the SNP population. These clinical practice guidelines will be communicated to providers utilizing provider newsletter and the Molina Medicare website. Molina will annually measure provider compliance with important aspects of the clinical practice guidelines and report results to providers.

11. Model of Care Training - The Molina Medicare SNP will provide initial and annual Molina SNP Model of Care training to all employed and contracted personnel. Web based or in person Model of Care training will be offered initially to all Medicare employees who have not completed such training and to all new employees. Verification of Medicare employee training will be through attendance logs for in person training or certificate of completion of web based training program.

All Molina Medicare Providers will be sent written Model of Care training via annual distribution of Provider education CDs. Providers may also have access to web based (still in development) or in person training on the Molina SNP Model of Care. Molina Medicare will issue a written request to Molina Medicare providers to participate in Model of Care training. Due to the very large community based network of providers and their participation in multiple Medicare SNPs it is anticipated that many providers will not accept the invitation to complete training. The Molina Medicare SNP Provider Services Department will identify key groups that have large numbers of Molina Medicare SNP Members and will conduct specific in person trainings with those groups. The development of model of care training materials will be the responsibility of a designated Molina UM Director or Medical Director. Implementation and oversight of completion of training will be the responsibility of a designated Molina Medicare Human Resource Manager (employees) and a designated Molina Medicare Provider Services Manager (providers). Employees will be required to complete training or undergo disciplinary action in accordance with Molina policies on completion of required training.

12. Health Risk Assessment - The Molina Medicare SNP will perform initial and annual Comprehensive Initial Health Risk Assessment of all SNP Members. Molina uses a general care management assessment tool that is embedded in Molina's electronic care/case/disease management software platform. Clinical Care Advance (a Trizetto product). This general care management assessment tool allows assessment of cultural and linguistic needs, medical history, medical utilization history, medications, home health needs and services, preventive health status, cognitive function, activities of daily living, mental/behavioral health problem screening, history, status and needs, social needs and concerns, barriers to care, end of life needs.

In addition to the general assessment, the SF12™ functional status and quality of life survey is performed and for select cases, a medication adherence assessment. There is also access to additional evidenced-based condition specific assessment tools depending on the health risks identified by member's responses (asthma, mental/behavioral health, COPD, diabetes, ESRD, HIV, etc.).

Molina will conduct initial assessments as soon as possible after member's enrollment in the plan but within ninety (90) days of enrollment. Existing Members who have not yet had an initial assessment will have an initial assessment conducted within one-hundred-eighty (180) days of the beginning of the 2013 calendar year. Annual re-assessments will occur within 12 months of the anniversary date of the completion of the initial risk assessment.

Molina plans to collect data for the Comprehensive Initial Health Risk Assessment and annual reassessments for each member utilizing a number of mechanisms including self reported member data collected via telephone IVR/internet responses, predictive modeling, claims reviews, telephone outreach by trained but non-professional staff, home visits, telephone interviews using professional clinical staff. Data collected will be entered into the formatted electronic assessment tools contained within Molina's

electronic care/case/disease management data platform (Clinical Care Advance). The combined set of data constitutes the Comprehensive Health Risk Assessment.

Once comprehensive health risk assessment data is gathered into the assessment tool Molina's staff of professional RN Case Managers, LCSW and RN Care Managers will review the information, decide if additional assessment is needed, follow stratification protocols and guide the development of an individualized care plan for the member. Using a flexible approach in collecting assessment information will allow Molina to focus precious professional clinical resources in analysis of assessment information, development of care plans and ongoing appropriate care/case management activities that provide high quality, effective health care for Members rather than routine data gathering.

Health risk assessment summaries will be sent via fax, mail or email following HIPAA compliant practices to the PCP, relevant specialists and other ICT Members without access to Clinical Care Advance. All Molina employee Members of the ICT have access to the Clinical Care Advance system. Members will be notified either verbally or in writing that they can request copies of their Comprehensive Health Risk Assessment results through a request to the Member Services Department.

Molina Medicare SNP Care Management Team Members will review health risk assessments for accuracy and make updates as they become aware of transitions in healthcare settings or changes in healthcare status of Members through mechanisms previously described.

13. Individualized Care Plan - Molina Medicare SNP professional healthcare staff (care managers, case managers, and social workers) will use information developed in the assessment process to develop individual care plans for Members based on analysis of the data and stratification of the individual member. Molina's care management information system, Clinical CareAdvance, provides standardized evidenced based care plans. Care management staff may also document member specific plans to address individual needs not included in standardized plans. In some instances as feasible based on stratification, health status and availability of the member/caregiver, Molina will seek opportunities to obtain member/caregiver involvement in care plan development. This is particularly critical when member self management goals are judged to be an important part of the care plan.

The plan of care elements may consist of member care preferences, need for utilization of medical, mental/behavioral health and supplemental Medicare benefits, end of life needs, social or community services needs and condition specific educational needs. Care plan elements will be structured in the form of goals (long and short term) and documentation will contain as appropriate identification of barriers, member self management plans, tasks (for ICT Members and member/caregivers), interventions and outcomes.

Member care plans are reviewed at least annually by professional clinical Molina staff in conjunction with annual Comprehensive Health Risk Assessments. Additional opportunities for review and revision of care plans may exist when Molina Care

Management Team Members are aware of member transitions in healthcare settings or significant changes in member health care status.

The plan of care is documented, reviewed and revised in the Clinical Care Advance system using template driven data entry to assure accuracy and completeness of care plans.

Individual member care plans will be sent via fax, mail or email following HIPAA compliant practices to the PCP, relevant specialists and other ICT Members without access to Clinical Care Advance. All Molina employee Members of the ICT have access to the Clinical Care Advance system. Members will be notified either verbally or in writing that they can request copies of their Individual member care plans through a request to the Member Services Department.

14. Communication - The Molina Medicare SNP will monitor and coordinate care for Members using an integrated communication system between Members/caregivers, the Molina ICT, other Molina staff, providers and CMS. Communications structure includes the following elements:

- a. Molina utilizes state of the art telephonic communications systems for telephonic interaction between Molina staff and all other stakeholders with capabilities for call center queues, call center reporting, computer screen sharing (available only to Molina staff) and audio conferencing. Molina maintains member and provider services call centers during CMS mandated business hours and a Nurse Advice Line (after hours) that Members and providers may use for communication and inquiries. Interactive voice response systems may be used for member assessment data gathering as well as general healthcare reminders. Electronic fax capability and Molina's ePortal allow for the electronic transmission of data for authorization purposes and transitions between settings. Faxed and electronic information is maintained in the member's Molina record.
- b. For communication of a general nature Molina uses newsletters (provider and member), the Molina Medicare website and blast fax communications (providers only). Molina may also use secure web based interfaces for member assessment, staff training, provider inquiries and provider training.
- c. For communication between Members of the ICT, Molina has available audio conferencing and audio video conferencing (Molina staff only). Most regular and ad-hoc ICT care management meetings will be held on a face to face basis with PCPs, other providers and member/caregivers joining via audio conferencing as needed.
- d. Written and fax documentation from Members and providers (clinical records, appeals, grievances) when received will be routed through secure mail room procedures to appropriate parties for tracking and resolution.
- e. Email communication may be exchanged with providers and CMS.

- f. Direct person to person communication may also occur between various stakeholders and Molina Medicare.
- g. Molina Quality Improvement Committees and Sub-Committees will meet regularly on a face to face basis with Members not able to attend in person attending via audio conferencing.

Tracking and documentation of communications occurs utilizing the following:

- a. The QNXT call tracking system will be used to document all significant telephonic conversations regarding inquiries from Members/caregivers and providers. All telephonically received grievances will be documented in the QNXT call tracking system. QNXT call tracking allows storage of a record of inquiries and grievances, status reporting and outcomes reporting.
- b. Communication between ICT Members and/or stakeholders will be documented in QNXT call tracking, QNXT clinical modules or Clinical Care Advance as appropriate. This documentation allows electronic status tracking and archiving of discussions. Written meeting summaries may be used when issues discussed are not easily documented using the electronic means documented above.
- c. Written and faxed communications when received are stored in an electronic document storage solution and archived to preserve the data. Written documents related to appeals and grievances result in a call tracking entry made in QNXT call tracking when they are received allowing electronic tracking of status and resolution.
- d. Email communication with stakeholders is archived in the Molina email server.
- e. Direct person-to-person communication will result in a QNXT call tracking entry or a written summary depending on the situation.
- f. Molina Committee meetings will result in official meeting minutes which will be archived for future reference.

A designated Molina Medicare SNP Quality Improvement Director will have responsibility to oversee, monitor and evaluate the effectiveness of the Molina Medicare SNP Communication Program.

15. Performance and Health Outcomes Measurement - The Molina Medicare SNP collects, analyzes, reports and acts on data evaluating the Molina SNP Model of Care. To evaluate the SNP Model of Care, Molina may collect data from multiple sources including:

- a. Administrative (demographics, call center data)
- b. Authorizations

- c. CAHPS
- d. Call Tracking
- e. Claims
- f. Clinical Care Advance (Care/Case/Disease Management Program data)
- g. Encounters
- h. HEDIS
- i. HOS
- j. Medical Record Reviews
- k. Pharmacy
- l. Provider Access Survey
- m. Provider Satisfaction Survey
- n. Risk Assessments
- o. Utilization
- p. SF12v2™ Survey Results
- q. Case Management Satisfaction Survey

Molina will use internal Quality Improvement Specialists, External Survey Vendors and Healthcare Analysts to collect analyze and report on the above data using manual and electronic analysis. Data analyzed and reported on will demonstrate the following:

- a. Improved member access to services and benefits.
- b. Improved health status.
- c. Adequate service delivery processes.
- d. Use of evidence based clinical practice guidelines for management of chronic conditions.
- e. Participation by Members/caregivers and ICT Members in care planning.
- f. Utilization of supplementary benefits.
- g. Member use of communication mechanisms.
- h. Satisfaction with Molina's Case Management Program.

Molina will submit CMS required public reporting data including:

- a. HEDIS Data
- b. SNP Structure and Process Measures
- c. Health Outcomes Survey
- d. CAHPS Survey

Molina will submit CMS required reporting data including some of the following:

- a. Audits of health information for accuracy and appropriateness.
- b. Member/caregiver education for frequency and appropriateness.
- c. Clinical outcomes.
- d. Mental/Behavioral health/psychiatric services utilization rates.
- e. Complaints, grievances, services and benefits denials.
- f. Disease management indicators.
- g. Disease management referrals for timeliness and appropriateness.
- h. Emergency room utilization rates.
- i. Enrollment/disenrollment rates.

- j. Evidence-based clinical guidelines or protocols utilization rates.
- k. Fall and injury occurrences.
- l. Facilitation of member developing advance directives/health proxy.
- m. Functional/ADLs status/deficits.
- n. Home meal delivery service utilization rates.
- o. Hospice referral and utilization rates.
- p. Hospital admissions/readmissions.
- q. Hospital discharge outreach and follow-up rates.
- r. Immunization rates.
- s. Medication compliance/utilization rates.
- t. Medication errors/adverse drug events.
- u. Medication therapy management effectiveness.
- v. Mortality reviews.
- w. Pain and symptoms management effectiveness.
- x. Policies and procedures for effectiveness and staff compliance.
- y. Preventive programs utilization rates (e.g., smoking cessation).
- z. Preventive screening rates.
- aa. Primary care visit utilization rates.
- bb. Satisfaction surveys for beneficiaries/caregivers.
- cc. Satisfaction surveys for provider network.
- dd. Screening for depression and drug/alcohol abuse.
- ee. Screening for elder/physical/sexual abuse.
- ff. Skilled nursing facility placement/readmission rates.
- gg. Skilled nursing facility level of care beneficiaries living in the community having admissions/readmissions to skilled nursing facilities.
- hh. Urinary incontinence rates.
- ii. Wellness program utilization rates.

The Molina Medicare SNP will use the above data collection, analysis and reporting to develop a comprehensive evaluation of the effectiveness of the Molina SNP Model of Care. The evaluation will include identifying and acting on opportunities to improve the program. A designated Molina Quality Improvement Director and/or Medical Director will have responsibility for monitoring and evaluating the Molina Medicare SNP Model of Care. Molina will notify stakeholders of improvements to the Model of Care by posting the Model of Care Evaluation on its website.

16. Care Management for the Most Vulnerable Subpopulations - The Molina Medicare SNP will identify vulnerable sub-populations including frail/disabled, multiple chronic conditions, ESRD and those nearing end of life by the following mechanisms:

- a. Risk assessments;
- b. Home visits;
- c. Predictive modeling;
- d. Claims data;
- e. Pharmacy data;
- f. Care/case/disease management activities;

- g.** Self referrals by Members/caregivers;
- h.** Referrals from Member Services; and/or
- i.** Referrals from providers.

Specific add-on services of most use to vulnerable sub-populations include:

- a.** Care management;
- b.** Case management;
- c.** Disease management; and/or
- d.** Provider home visits.

The needs of the most vulnerable population will be met within the Molina Medicare SNP Model of Care by early identification and higher stratification/priority in Molina programs including Disease Management, Care Management, and Case Management. These Members will be managed more aggressively and more frequently by the ICT. This will assure that they are receiving all necessary services and that they have adequate care plans before, during and after transitions in health care settings or changes in healthcare status.

IX. Members' Rights and Responsibilities

Molina Medicare members have certain rights to help protect them. In this chapter, Member rights and responsibilities are outlined based on Molina Medicare of Ohio's Evidence of Coverage document that members receive annually.

A. Molina Members have a right to:

Have information provided in a way that works for them (in languages other than English that are spoken in our service area, in Braille, in large print or other alternate formats. To get information from us in a way that works for members, please call Member Services at **(866) 472-4584**. Molina Medicare plans have translation services available to answer questions from non-English speaking Members and can also provide information in Braille, in large print, or other alternate formats. If Members are eligible for Medicare because of disability, Molina Medicare is required to give information about the plan's benefits that is accessible and appropriate for them.

- 1. Be treated with fairness and respect at all times.** Molina Medicare must obey laws that protect members from discrimination or unfair treatment and not discriminate based on a race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.
- 2. If members want more information or have concerns** about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights 1-800-368-1019 (TTY 1-800-537-7697)** or their local Office for Civil Rights. If members have a disability and need help with access to care, please call Member Services at **(866) 472-4584**. If members have a complaint, such as a problem with wheelchair access, Member Services can help.
- 3. Get timely access to covered services and drugs.** Members have the right to choose a primary care provider (PCP) in the Molina Medicare network to provide and arrange for covered services. Members may call Member Services at **(866) 472-4584** to learn which doctors are accepting new patients. Members also have the right to go to a women's health specialist (such as a gynecologist) without a referral. Members have the right to **get appointments and covered services from the plan's network of providers within a reasonable amount of time.** This includes the right to get timely services from specialists. Members also have the right to get prescriptions filled or refilled at any network pharmacies without long delays. If members think that they are not getting medical care or Part D drugs within a reasonable amount of time, they may call **(866) 472-4584**.
- 4. Have their privacy and personal health information protected.** Federal and state laws protect the privacy of medical records and personal health information. Molina Medicare protects personal health information as required by these laws.

- A member’s “personal health information” includes the personal information given when they enrolled in this plan as well as medical records and other medical and health information.
- The laws that protect a member’s privacy give them rights related to getting information and controlling how health information is used. Members are given a written notice, called a “Notice of Privacy Practices,” that tells about these rights and explains the protection of the privacy of their health information.

5. Be given information about our plan, our network of providers and covered services. Members have the right to get several kinds of information by calling Member Services at **(866) 472-4584**.

- Information about Molina Medicare; including for example, information about Molina’s financial condition. It also includes information about the number of appeals made by Members and the plan’s performance ratings, including how it has been rated by plan members and how it compares to other Medicare Advantage health plans.
- Information about our network providers including our network pharmacies. For example, members have the right to get information about the qualifications of the providers and pharmacies in the Molina Medicare network and how providers are paid. For more detailed information about providers or pharmacies, Members may call Member Services at **(866) 472-4584** or visit our website at www.molinamedicare.com.
- Information about coverage and rules to follow in using coverage. Members are provided with what medical services are covered, any restrictions to their coverage, and what rules must be followed to get covered medical services.
- Information about why something is not covered and what can be done about it.

6. Be supported in their right to make decisions about their care and to know about all of their treatment choices in a way they can understand. Members have the right to be told about all of the treatment options that are recommended for their condition, no matter what they cost or whether they are covered. It also includes being told about programs offered to help members manage their medications and use drugs safely.

7.

- **Know about the risks.** Members have the right to be told about any risks involved in their care; be told in advance if any proposed medical care or treatment is part of a research experiment and they always have the choice to refuse any experimental treatments.
- **The right to say “no.”** They have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if their doctor advises them not to leave. They also have the right to stop taking medication. Of

course, if they refuse treatment or stop taking medication, they accept full responsibility for what happens to their body as a result.

- **Receive an explanation if they are denied coverage for care.** They have the right to receive an explanation from **Molina Medicare** if a provider has denied care that they believe they should receive.
- **Have the right to give instructions about what is to be done if they are not able to make medical decisions for themselves through an advance directive.** According to law, no one can deny them care or discriminate against them based on whether or not they have signed an advance directive. If a member has signed an advance directive, and they believe that a doctor or hospital hasn't followed the instructions in it, a complaint may be filed with:

For Practitioners;
State Medical Board of Ohio
Public Inquiries
30 East Broad Street, 3rd
Columbus, OH 43215-6127
Floor
(800) 554-7717

For Facilities:
Ohio Department of Health
Division of Quality Assurance
Provider and Consumers Services Unit
246 North High Street
Columbus, OH 43215
(800) 342-0553
(800) 669-3534 Health Care Safety
(800) 752-8649 Hearing Impaired (TTY/TDD)
(800) 584-6057 Fax
Email: HCCompliant@odh.ohio.gov

- 8. Make complaints and to ask us to reconsider decisions we have made.** If Members have any problems or concerns about their covered services or care, they may need to ask Molina Medicare to make a coverage decision, make an appeal to change a coverage decision, or make a complaint. Whatever they do – ask for a coverage decision, make an appeal, or make a complaint – **Molina Medicare is required to treat them fairly.** They have the right to get a summary of information about the appeals and complaints that other Members have filed in the past. To get this information, please call Member Services at **(866) 472-4584.**

B. Additional Information about Members' Rights:

What can Members do if they think they are being treated unfairly or their rights are not being respected? If members think they have been treated unfairly or their rights have

not been respected due to race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, they should call the Department of Health and Human Services' **Office for Civil Rights** at **1-800-368-1019** or **TTY 1-800-537-7697**, or call the local Office for Civil Rights.

If Members think they have been treated unfairly or their rights have not been respected, *and* their issue is *not* about discrimination, they can get help dealing with the problem they are having by calling:

1. **Molina Member Services** at **(866) 472-4584**.
2. **The State Health Insurance Assistance Program**, which is a government program with trained counselors in every state. In Ohio, the State Health Insurance Assistance Program is called:

Ohio Senior Health Insurance Information Program (OSHIIP)
Ohio Department of Insurance
50 W. Town Street
Third Floor – Suite 300
Columbus, OH 43215
www.oshiip.org

3. **Medicare** - Members may visit the Medicare website (<http://www.medicare.gov>) to read or download the publication “Their Medicare Rights & Protections;” or, members can call **1-800-MEDICARE (1-800-633-4227)** 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

C. Molina Medicare Members have a responsibility to:

1. Get familiar with their covered services and the rules they must follow to get these covered services.
2. Inform Molina if they have any other health insurance coverage or prescription drug coverage.
3. Tell their doctor and other healthcare providers that they are enrolled in Molina Medicare, and show how their plan membership card and their Medicaid card whenever they get their medical care or Part D prescription drugs.
4. Help their doctors and other providers help them by giving them information, asking questions and following through on their care.
5. Be considerate. We expect all our members to respect the rights of other patients. We also expect them to act in a way that helps the smooth running of their doctor's office, hospitals, and other offices.

6. Pay what they owe. As a plan member, they are responsible for these payments:

- They must pay any applicable premiums for some of their medical services or drugs covered by the plan. Some members must pay Part A and B premiums.
- They must pay their share of the cost when they get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost).
- If they get any medical services or drugs that are not covered by Molina Medicare or by other insurance they may have, they must pay the full cost. If they disagree, they may appeal.
- If they are required to pay a late enrollment penalty, they must pay it to remain a member of Molina Medicare.

7. Tell Molina if they move. If they are going to move, it is important to tell us right away.

- If they move outside of Molina Medicare's service area, they cannot remain a member.
- If they move within our service area, we still need to know so we can keep their membership record up to date and know how to contact them.

8. Call Member Services for help if they have questions or concerns. We also welcome any suggestions they may have for improvement. Member Services can be reached at **(866) 472-4584**.

X. Provider Responsibilities

A. Provision of Covered Services

Providers will render covered services to Members within the scope of the provider's business and practice, in accordance with the provider's contract, Molina Medicare's policies and procedures, the terms and conditions of the Molina Medicare product which covers the member and the requirements of any applicable government-sponsored program.

B. Standard of Care

Providers will render covered services to Members at a level of care and competence that equals or exceeds the generally accepted and professionally recognized standard of practice at the time of treatment, all applicable rules and/or standards of professional conduct and any controlling governmental licensing requirements.

C. Facilities, Equipment and Personnel

The provider's facilities, equipment, personnel and administrative services should be at a level and quality necessary to perform duties and responsibilities in order to meet all applicable legal requirements including the accessibility requirements of the Americans with Disabilities Act.

D. Referrals

When a provider determines that it is medically necessary to consult or obtain services from other specialty health professionals, the provider should make a referral in accordance with **Section VIII – Utilization Management, Section T** – of this Manual unless the situation is one involving the delivery of emergency services. Providers should coordinate the provision of specialty care in order to ensure continuity of care. Providers need to document referrals that are made in the patient's medical record. Documentation needs to include the specialty, services requested and diagnosis for which the referral is being made.

E. Contracted Providers

Except in the case of emergency services or after receiving prior authorization of Molina Medicare, providers should direct Members to use only those health professionals, hospitals, laboratories, skilled nursing and other facilities and providers, which have contracted with Molina Medicare.

F. Member Eligibility Verification

Providers should verify eligibility of Molina Members prior to rendering services. Options Plus (HMO SNP) members may switch health plans at any time during the year.

G. Admissions

Providers are required to comply with Molina Medicare's facility admission and prior authorization procedures.

H. Prescriptions

Providers are required to abide by Molina Medicare drug formularies and prescription policies, including those regarding the prescription of generic or lowest cost alternative brand name pharmaceuticals. Providers should obtain prior authorization from the Molina Medicare Pharmacy Department if the provider believes it is necessary to prescribe a non-formulary drug or a brand name drug when generics are available.

The only exceptions are prescriptions and pharmaceuticals ordered for inpatient facility services. Molina Medicare's contracted pharmacies/pharmacists may substitute generics for brand name pharmaceuticals unless counter indicated on the prescription by the provider.

I. Subcontract Arrangements

Any subcontract arrangement entered into by a provider for the delivery of covered services to Members must be in writing and will bind the provider's subcontractors to the terms and conditions of the provider's contract including, but not limited to, terms relating to licensure, insurance, and billing of Members for covered services.

J. Availability of Services

Providers must make necessary and appropriate arrangements to assure the availability of covered services to Members on a twenty-four (24) hours a day, seven (7) days a week basis, including arrangement to assure coverage of member visits after hours. Providers are to meet the applicable standards for timely access to care and services as outlined in this manual in Chapter VI – Quality Improvement, taking into account the urgency of the need for the services.

K. Treatment Alternatives and Communication with Members

Molina Medicare endorses open provider-member communication regarding appropriate treatment alternatives and any follow up care. Molina Medicare promotes open discussion between provider and Members regarding medically necessary or appropriate patient care, regardless of covered benefits limitations. Providers are free to communicate any and all treatment options to Members regardless of benefit coverage limitations. Providers are also encouraged to promote and facilitate training in self-care and other measures Members may take to promote their own health.

L. Nondiscrimination

Providers will not differentiate or discriminate in providing covered services to Members because of race, color, religion, national origin, ancestry, age, sex, marital status, sexual orientation, physical, sensory or mental handicap, socioeconomic status, or participation in publicly financed healthcare programs. Providers are to render covered services to Members in the same location, in the same manner, in accordance with the same standards and within the same time availability regardless of payer.

M. Maintaining Member Medical Record

Providers are to maintain an accurate and readily available medical record for each member to whom health care services are rendered. Providers are to initiate a medical record upon the member's first visit. The member's medical record should contain all information required by state and federal law, generally accepted and prevailing professional practice, applicable government sponsored health programs and all Molina Medicare's policies and procedures. Providers are to retain all such records for at least ten (10) years.

N. Confidentiality of Member Health Information

Providers are expected to comply with all applicable state and federal laws. Refer to Chapter VII for HIPAA requirements and information.

O. HIPAA Transactions

Providers are expected to comply with all HIPAA TCI (transactions, code sets, and identifiers) regulations. Refer to Chapter VII for HIPAA requirements and information.

P. National Provider Identifier (NPI)

Providers are expected to comply with all HIPAA NPI regulations. Refer to **Chapter VII - HIPAA** requirements and information.

Q. Delivery of Patient Care Information

Providers are to promptly deliver to Molina Medicare, upon request and/or as may be required by state or federal law, Molina Medicare's policies and procedures, applicable government sponsored health programs, Molina Medicare's contracts with the government agencies, or third party payers, any information, statistical data, encounter data, or patient treatment information pertaining to Members served by the provider, including but not limited to, any and all information requested by Molina Medicare in conjunction with utilization review and management, grievances, peer review, HEDIS Studies, Molina Medicare's Quality Improvement Program, or claims payment. Providers will further provide direct access to patient care information as requested by Molina Medicare and/or as required to any governmental agency or any appropriate state and federal authority having jurisdiction. Molina Medicare will have the right to withhold compensation from the provider

in the event that the provider fails or refuses to promptly provide any such information to Molina Medicare.

CMS has specific guidelines for the retention and disposal of Medicare records. Please refer to [CMS General Information, Eligibility, and Entitlement Manual](#), Chapter 7, Chapter 30.30 for guidance.

R. Member Access to Health Information

Providers are expected to comply with all applicable state and federal laws. Refer to Chapter VII for HIPAA requirements and information.

S. Participation in Grievance Program

Providers are expected to participate in Molina Medicare's Grievance Program and cooperate with Molina Medicare in identifying, processing, and promptly resolving all member complaints, grievances, or inquiries. If a member has a complaint regarding a provider, the provider will participate in the investigation of the grievance. If a member appeals, the provider would participate by providing medical records or statement if needed. Please refer to Chapter XIV regarding members' appeals and grievances.

T. Participation in Quality Improvement Program

Providers are expected to participate in Molina Medicare's Quality Improvement Program and cooperate with Molina Medicare in conducting peer review and audits of care rendered by providers.

U. Participation in Utilization Review and Management Program

Providers are required to participate in and comply with Molina Medicare's utilization review and management programs, including all policies and procedures regarding prior authorizations, and cooperate with Molina Medicare in audits to identify, confirm, and/or assess utilization levels of covered services.

V. Participation in Credentialing

Providers will participate in Molina Medicare's credentialing and re-credentialing process and will satisfy, throughout the term of their contract, all credentialing and re-credentialing criteria established by Molina Medicare. The provider is to immediately notify Molina Medicare of any change in the information submitted or relied upon by the provider to achieve credentialed status. If the provider's credentialed status is revoked, suspended or limited by Molina Medicare, Molina Medicare may, at its discretion, terminate the contract and/or reassign Members to another provider.

W. Delegation

The delegated entities will accept of credentialing responsibilities at Molina Medicare's request and shall cooperate with Molina Medicare in establishing and maintaining appropriate mechanisms within the provider's organization. If delegation of responsibilities is revoked, Molina Medicare will reduce any otherwise applicable payments owing to the delegated entity. Delegated services may include but not be limited to Claims, Utilization Management, Credentialing, Call Center and certain administrative functions that meet the criteria for delegation.

Delegated entities shall comply with all state and federal requirements including but not limited to:

- Reporting
- Timeliness standards for organizational determinations
- Training and education

X. Provider Manual

Providers will comply and render covered services in accordance with the contents, instructions and procedures as outlined in this manual, which may be amended from time to time at Molina Medicare's sole discretion.

Y. Health Education/Training

Providers are to participate in and cooperate with Molina Medicare provider education and training efforts as well as member education and efforts. Providers are also to comply with all Molina Medicare's health education, cultural and linguistic standards, policies, and procedures.

Z. Promotional Activities

At the request of Molina Medicare, the provider may display Molina Medicare promotional materials in its offices and facilities as practical, and cooperate with and participate in all reasonable Molina Medicare marketing efforts. Providers shall not use Molina Medicare's name in any advertising or promotional materials without the prior written permission of Molina Medicare.

Providers are responsible for complying with the Medicare Marketing Guidelines. The provisions that apply to providers are identified in the Guidelines. CMS periodically updates and revises the Guidelines. Providers should keep apprised of any updates that are issued by CMS. For your convenience, we have provided the following link to CMS's website: <http://www.cms.hhs.gov/manuals/downloads/mc86c03.pdf>

XI. Claims and Compensation

When billing for services rendered to Molina Medicare Members, providers must bill with the most current Medicare approved coding (ICD-9, CPT, HCPCS, etc.) available. Claims must be submitted using the proper claim form/format, e.g., for paper claims a CMS1500 or UB04, and for an electronically submitted claim – in approved ANSI/HIPAA format.

It is recommended that claims be submitted as if they are being billed to Medicare fee-for-service. The following information must be included on every claim:

A. Data Elements Required

- Member name, date of birth and Molina Medicare member ID number.
- Member's gender.
- Member's address.
- Date(s) of service.
- Valid ICD-9 diagnosis and procedure codes.
- Valid revenue, CPT or HCPCS for services or items provided.
- Valid Diagnosis Pointers
- Total billed charges for service provided.
- Place and type of service code.
- Days or units as applicable.
- Provider tax identification.
- National Provider Identifier (NPI).
- Rendering Provider as applicable.
- Provider name and billing address.
- Place of service and type (for facilities).
- Disclosure of any other health benefit plans.
- E-signature.
- Service Facility Location (Box 32 of CMS 1500 form)

Molina Medicare will process only legible claims. Handwritten claims are not acceptable and will be rejected. Incomplete, inaccurate, or untimely re-submissions may result in denial of the claim.

Please submit paper claims to Molina Medicare's office at the following address:

**Molina Medicare Claims
PO Box 22811
Long Beach, CA 90801**

To overnight claims (physical address):

**Molina Healthcare Inc.
Medicare Claims Processing
200 Oceangate, Suite 100
Long Beach, CA 90802**

B. Hospital-Acquired Conditions and Present on Admission Program

The Deficit Reduction Act of 2005 (DRA) mandated that Medicare establish a program that would reduce reimbursement for certain conditions that occur as a direct result of a hospital stay. CMS titled the program “Hospital-Acquired Conditions and Present on Admission Indicator Reporting” (HAC and POA).

Hospital Acquired Conditions include the following events occurring during a hospital stay:

- Catheter-associated urinary tract infection (UTI)
- Pressure ulcers (bed sores)
- Serious preventable event – object left in during surgery
- Serious preventable event – air embolism
- Serious preventable event – blood incompatibility
- Vascular catheter-associated infections
- Mediastinitis after coronary artery bypass graft surgery (CABG)
- Hospital-acquired injuries – fractures, dislocations, intracranial injury, crushing injury, burn, and other unspecified effects of external causes

The HAC/POA program was implemented by Medicare in the following stages:

- October 1, 2007 – Medicare required Inpatient Prospective Payment System (IPPS) hospitals to submit POA indicators on diagnoses for inpatient discharges.
- April 1, 2008 – Medicare started returning claims with no payment if the POA indicator is not coded correctly (missing POA indicators, invalid POA indicators or inappropriate POA coding on POA-exempt diagnosis codes).
- October 1, 2008, hospitals no longer received additional payments for conditions acquired during the patient’s hospitalization.

Effective for inpatient discharges on or after January 20, 2009, Molina Medicare adopted the Medicare HAC/POA program. What this means to providers:

- Acute Inpatient Prospective Payment System (IPPS) Hospital claims will be returned with no payment if the POA indicator is coded incorrectly or missing; and
- No additional payment will be made on IPPS hospital claims for conditions that are acquired during the patient’s hospitalization.

If you would like to find out more information regarding the Medicare HAC/POA program, including billing requirements, the following CMS site provides further information:

<http://www.cms.hhs.gov/HospitalAcqCond/>

C. Claims Submission Questions

Molina Medicare is concerned that all provider questions and concerns about claims are answered timely. Please refer to contact information above and in Section III.

D. Electronic Claim Submissions

Molina Medicare uses numerous clearing houses for electronic submissions of CMS1500s and facility/institutional claims. You can contact your local Provider Service Representative for the lists of clearing houses. **Please use Molina Healthcare of Ohio's Payer ID number – 20149 – when submitting claims electronically.**

Molina Medicare encourages providers to track all electronic submissions using the acknowledgement reports received from the provider's current clearing house. These reports assure claims are received for processing in a timely manner. Additionally, Emdeon clearing house issues an acknowledgement report to the submitting Provider within five (5) to seven (7) business days of claim transmission. Any problems experienced with claims transmission should be addressed to the Provider's current clearinghouse representative.

E. Timely Claim Filing

Claims for covered services rendered to Molina Medicare Members must be filed within one (1) calendar year after the date of service.

F. Timely Claims Processing

A complete claim is a claim that has no defect, impropriety, lack of any required substantiating documentation as outlined in Part A above, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim. All hard copy claims received Molina Medicare will be clearly stamped with date of receipt. Claim payment will be made to contracted providers in accordance with the timeliness standards set forth by the Centers for Medicare and Medicaid Services (CMS).

G. Billing Options/ Molina Members

1. Providers contracted with Molina Medicare cannot bill the member for any covered benefits. The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.
2. Providers may not charge Members fees for covered services beyond copayments or coinsurance.
3. Providers agree that under no circumstance shall a member be liable to the Provider for any sums owed by Molina Medicare to the Provider. Members who are dually eligible for Medicare and Medicaid shall not be held liable for Medicare Part A and B cost sharing when the State or another payer such as a Medicaid Managed Care Plan is responsible for paying such amounts.
4. Provider agrees to accept payment from Molina Medicare as payment in full, or bill the appropriate responsible party, for any Medicare Part A and B cost sharing that is covered by Medicaid.

5. Provider may not bill a Molina Medicare member for any unpaid portion of the bill or for a claim that is not paid with the following exceptions:
- The member has been advised by the provider that the service is not a covered benefit and the provider has documentation.
 - The member has been advised by the provider that he/she is not contracted with Molina Healthcare and has documentation.
 - The member agrees in writing to have the service provided with full knowledge that they are financially responsible for payment.
 - A member is responsible for payment of a hospital outpatient emergency room visit if it is determined that an emergency did not exist at the time the service was provided except in those circumstances in which the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of medical attention could reasonably be expected by a prudent layperson to result in placing the member's health in jeopardy, impairment or dysfunction. The member may only be billed for the emergency room charges, but cannot be billed for the ancillary charges (e.g., laboratory & radiology services)

H. Provider Claim Redeterminations

Providers seeking a redetermination of a claim previously adjudicated must request such action within one-hundred-twenty (120) days of Molina Medicare's original remittance advice date. Additionally, the item(s) being resubmitted should be clearly marked as a redetermination and must include the following:

- Requests must be fully explained as the reason for redetermination
- Previous claim and remittance advice, any other documentation to support the request and a copy of the referral/authorization form (if applicable) must accompany the request.
- Requests for claim redetermination should be mailed to the address referenced at the end of this section.
- Corrected claim submissions are not adjustments and should be directed through the original submission process marked as a corrected claim or it will result in the claim being denied.

I. Overpayments and Refund Requests

In the event Molina Medicare finds an overpayment on a claim or must recoup money, the provider will be mailed a letter requesting a refund of the overpayment. The provider has sixty (60) calendar days to refund Molina Medicare. If the refund is not received within that time, the amount overpaid will be deducted from the provider's next claim payment.

All questions pertaining to refund requests are to be directed to the Claims Customer Service Department **toll free at (800) 642-4168**.

J. Third Party Liability (TPL)/Coordination of Benefits (COB)

For Members enrolled in a Molina Medicare plan, Molina Medicare and/or contracted Medical Groups/IPAs are financially responsible for the care provided to these Members. Molina Medicare will pay claims for covered services; however if TPL/COB is determined post payment, Molina Medicare will attempt to recover any overpayments.

K. Medicaid coverage for Molina Medicare Members

There are certain benefits that will not be covered by Molina Medicare but may be covered by **fee-for-service Medicaid**. In this case, the provider should bill Medicaid with a copy of the Molina Medicare remittance advice and the associated state agency will process the claim accordingly.

After exhausting all other primary coverage benefits, providers may submit claims to Molina Medicare. A copy of the remittance advice from the primary payer must accompany the claim or the claim will be denied. If the primary insurance paid more than Molina Medicare's contracted allowable rate the claim is considered paid in full and zero dollars will be applied to claim.

L. Provider Claims Appeal Claims Process

The Provider Appeal/Dispute Claims Review process, which differs from the member appeals process, offers recourse for Providers, who are dissatisfied with a claim denial or decision. Molina Healthcare of Ohio will consider requests that are submitted by either the Provider directly or by parties acting on behalf of the Provider (such as attorneys and collection agencies). Provider Appeal requests must be submitted to Molina Healthcare of Ohio within one-hundred-twenty (120) days of the initial Remittance.

The party requesting an appeal must submit a letter to Molina Medicare clearly identified as "Claim Appeal Request." The written correspondence must refer to the claim number.

Provider Appeal/Dispute requests must include all pertinent information such as:

- The original claim;
- Prior authorization letter;
- Claim denial letter;
- Supporting medical records; and
- Any new information pertinent to the Denied Claims Review request.

Requests submitted without this documentation may be delayed. Requests submitted more than one-hundred-twenty (120) days from the original decision may be denied. Request for Denied Claims Review should be mailed to the address specified in Section A above.

The Provider will be notified of Molina Healthcare of Ohio's decision in writing within sixty (60) calendar days of receipt of the Claims Appeals/Dispute request. Providers may **not**

“bill” the member when a denial for covered services is upheld per review. A redetermination request, which differs from “Provider Appeals/Dispute” request, must be submitted within one-hundred-twenty (120) days of the original RA from Molina Medicare in order to be considered. Providers may request a claim redetermination when the claim was incorrectly denied as a duplicate or due to claims examiner or data-entry error.

If the Provider has a direct contract with the delegated medical group/IPA, the Provider must make an initial review request or a claim adjustment request through that group.

M. Claims Review and Audit

Providers acknowledge Molina Medicare’s right to review Provider’s claims prior to payment for appropriateness in accordance with industry standard billing rules, including, but not limited to:

- Current UB manual and editor;
- Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) coding;
- CMS billing and payment rules;
- National Correct Coding Initiatives (NCCI) Edits; and
- FDA definitions and determinations of designated implantable devices and/or implantable orthopedic devices.

Providers acknowledge Molina Medicare’s right to conduct such review and audit on a line-by-line basis or on such other basis as Molina Medicare deems appropriate and Molina Medicare’s right to adjust the bill to pay the revised allowable level.

Providers acknowledge Molina Medicare’s right to conduct utilization reviews to determine medical necessity and to conduct post-payment billing audits. The Provider shall cooperate with Molina Medicare’s audits of claims and payments by providing access to:

- Requested claims information;
- All supporting medical records;
- Provider’s charging policies; and
- Other related data.

Molina Medicare will use established industry claims adjudication and/or clinical practices, state and federal guidelines, and/or Molina Medicare’s policies and data to determine the appropriateness of the billing, coding and payment.

N. Oversight and Monitoring of Delegated Medical Groups/IPA – Claims and Financial Reporting

Molina Medicare routinely monitors its network of delegated medical groups/IPAs and other delegated entities for compliance with various standards. These requirements include, but are not limited to:

1. Claims Timeliness Reporting/Audits - Molina Medicare requires delegated medical group/IPAs and other delegated entities to submit monthly claims processing reports. These reports are due to Molina Medicare by the 15th of each month for all claims processed in the previous month.

- Ninety-five percent (95%) of the monthly volume of non contracted “clean” claims are to be adjudicated within thirty (30) calendar days of receipt.
- Ninety-five percent (95%) of the monthly volume of contracted claims are to be adjudicated within sixty (60) calendar days of receipt.
- Ninety-five percent (95%) of the monthly volume of non clean non contracted claims shall be paid or denied within sixty (60) calendar days of receipt.

Molina Medicare requires the Medical Groups/IPAs and other delegated entities to achieve passing claims audit scores. Claims audits are conducted annually. More frequent audits are conducted when the Medical Group/IPA and other delegated entity does not achieve the timely processing requirements referenced above.

2. Encounter Data Reporting - Molina Medicare will accept encounter data via hard copy (CMS1500 or UB04) or electronically (in specified formats). Electronic encounter data is due to Molina Medicare by the fifth day of the second month following the encounter (e.g., by August 5th for encounters occurring in June).

Hard copy encounter data is due to Molina Medicare within ninety (90) days from the end of the month following the encounter (e.g., by October 31st for all encounters occurring in July).

O. Provider Reconsideration of Delegated Claims

Providers requesting a reconsideration, correction or reprocessing of a claim previously adjudicated by an entity that is delegated for claims payment must submit their request to the delegated entity responsible for payment of the original claim.

XII. Fraud, Waste and Abuse Program

A. Introduction

Molina is dedicated to the detection, prevention, investigation, and reporting of potential health care fraud, waste, and abuse. As such, Molina's Compliance department maintains a comprehensive plan, which addresses how Molina will uphold and follow state and federal statutes and regulations pertaining to fraud, waste, and abuse. Molina's Special Investigation Unit (SIU) supports Compliance in its efforts to deter and prevent fraud, waste, and abuse by conducting investigations to identify and report findings to the appropriate regulatory and/or law enforcement agencies.

B. Definitions

- 1. Fraud:** Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. 18 U.S.C. § 1347.
- 2. Waste:** Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.
- 3. Abuse:** Actions that may, directly or indirectly, result in: unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

C. Mission

Molina regards health care fraud, waste, and abuse as unacceptable, unlawful, and harmful to the provision of quality health care in an efficient and affordable manner. Molina has therefore implemented a plan to detect, prevent, investigate, and report suspected health care fraud, waste, and abuse in order to reduce health care cost and to promote quality health care.

D. Compliance Department Contact Information

Tel: (866) 665-4626
Fax: (877) 665-4620
Email: corporatecompliance@molinahealthcare.com
Mail: Confidential
Compliance Official
Molina Healthcare, Inc.
200 Oceangate, Suite 100
Long Beach, CA 90802

E. Regulatory Requirements

- 1. Federal False Claims Act** - The False Claims Act is a federal statute that covers fraud involving any federally funded contract or program, including the Medicare and Medicaid programs. The act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U.S. Government for payment.

The term “knowing” is defined to mean that a person with respect to information:

- Has actual knowledge of falsity of information in the claim;
- Acts in deliberate ignorance of the truth or falsity of the information in a claim; or
- Acts in reckless disregard of the truth or falsity of the information in a claim.

The act does not require proof of a specific intent to defraud the U.S. government. Instead, healthcare providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims to the government, such as knowingly making false statements, falsifying records, double-billing for items or services, submitting bills for services never performed or items never furnished or otherwise causing a false claim to be submitted.

Deficit Reduction Act - The Deficit Reduction Act (DRA) aims to cut fraud, waste and abuse from the Medicare and Medicaid programs. Healthcare entities like Molina who receive or pay out at least five million dollars in Medicaid funds per year must comply with the DRA. As a contractor doing business with Molina, providers and their staff have the same obligation to report any actual or suspected violation of Medicare/Medicaid funds by fraud, waste or abuse.

Entities must have written policies that inform employees, contractors, and agents of the following:

- The Federal False Claims Act and state laws pertaining to submitting false claims;
- How providers will detect and prevent fraud, waste, and abuse; and
- Employee protection rights as whistleblowers.

The Federal False Claims Act and state Medicaid False Claims Acts have Qui Tam language commonly referred to as “whistleblower” provisions. These provisions encourage employees (current or former) and others to report instances of fraud, waste or abuse to the government. The government may then proceed to file a lawsuit against the organization/individual accused of violating the False Claims acts. The whistleblower may also file a lawsuit independently. Cases found in favor of the government will result in the whistleblower receiving a portion of the amount awarded to the government.

Whistleblower protections state that employees who have been discharged, demoted, suspended, threatened, harassed or otherwise discriminated against due to their role in furthering a false claim are entitled to all relief necessary to make the employee whole including:

- Employment reinstatement at the same level of seniority;
- Two (2) times the amount of back pay plus interest; and

- Compensation for special damages incurred by the employee as a result of the employer's inappropriate actions.

Affected entities who fail to comply with the law will be at risk of forfeiting all payments until compliance is met. Molina will take steps to monitor Molina contracted providers to ensure compliance with the law.

Anti-Kickback Statute – Provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce or reward business payable or reimbursable under the Medicare or other Federal health care programs.

Stark Statute – Similar to the Anti-Kickback Statute, but more narrowly defined and applied. It applies specifically to Medicare and Medicaid services provided only by physicians, rather than by all health care practitioners.

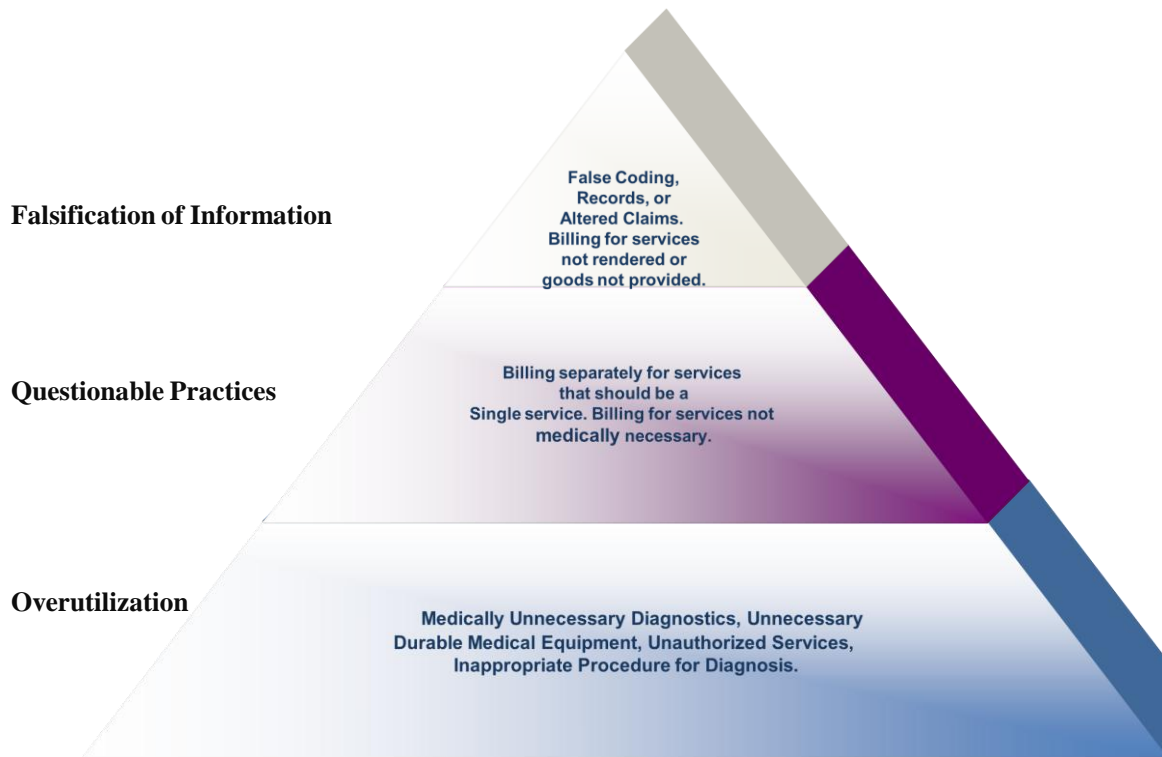
Sarbanes-Oxley Act of 2002 – Requires certification of financial statements by both the Chief Executive Officer and the Chief Financial Officer. The Act states that a corporation must assess the effectiveness of its internal controls and report this assessment annually to the Securities and Exchange Commission.

F. Examples of Fraud, Waste and Abuse by a Provider

The types of questionable provider schemes investigated by Molina include, but are not limited to the following:

1. Altering claim forms, electronic claim forms, and/or medical record documentation in order to get a higher level of reimbursement.
2. Balance billing a Medicare and/or Medicaid member for Medicare and/or Medicaid covered services. This includes asking the member to pay the difference between the discounted and negotiated fees, and the provider's usual and customary fees.
3. Billing and providing for services to members that are not medically necessary.
4. Billing for services, procedures and/or supplies that have not been rendered.
5. Billing under an invalid place of service in order to receive or maximize reimbursement.
6. Completing certificates of Medical Necessity for members not personally and professionally known by the provider.
7. Concealing a member's misuse of a Molina identification card.
8. Failing to report a member's forgery or alteration of a prescription or other medical document.

- 9.** False coding in order to receive or maximize reimbursement.
- 10.** Inappropriate billing of modifiers in order to receive or maximize reimbursement.
- 11.** Inappropriately billing of a procedure that does not match the diagnosis in order to receive or maximize reimbursement.
- 12.** Knowingly and willfully referring patients to health care facilities in which or with which the physician has a financial relationship for designated health services (The Stark Law).
- 13.** Knowingly and willfully soliciting or receiving payment of kickbacks or bribes in exchange for referring patients.
- 14.** Not following incident to billing guidelines in order to receive or maximize reimbursement.
- 15.** Overutilization
- 16.** Participating in schemes that involve collusion between a provider and a member that result in higher costs or charges.
- 17.** Questionable prescribing practices.
- 18.** Unbundling services in order to get more reimbursement, which involves separating a procedure into parts and charging for each part rather than using a single global code.
- 19.** Underutilization, which means failing to provide services that are medically necessary.
- 20.** Upcoding, which is when a provider does not bill the correct code for the service rendered, and instead uses a code for a like services that costs more.
- 21.** Using the adjustment payment process to generate fraudulent payments.



G. Examples of Fraud, Waste, and Abuse by a Member

The types of questionable member schemes investigated by Molina include, but are not limited to, the following:

- Benefit sharing with persons not entitled to the member’s Medicare and/or Medicaid benefits.
- Conspiracy to defraud Medicare and/or Medicaid.
- Doctor shopping, which occurs when a member consults a number of providers for the purpose of inappropriately obtaining services.
- Falsifying documentation in order to get services approved.
- Forgery related to health care.
- Prescription diversion, which occurs when a member obtains a prescription from a provider for a condition that he/she does not suffer from and the member sells the medication to someone else.

H. Prepayment Fraud, Waste and Abuse Detection Activities

Through implementation of claims edits, Molina's claims payment system is designed to audit claims concurrently, in order to detect and prevent paying claims that are inappropriate.

I. Post-payment Recovery Activities

The terms expressed in this section of this Provider Manual are incorporated into the Provider Agreement, and are intended to supplement, rather than diminish, any and all other rights and remedies that may be available to Molina under the Provider Agreement or at law or equity. In the event of any inconsistency between the terms expressed here and any terms expressed in the Provider Agreement, the parties agree that Molina shall in its sole discretion exercise the terms that are expressed in the Provider Agreement, the terms that are expressed here, its rights under law and equity, or some combination thereof.

Provider will provide Molina, governmental agencies and their representatives or agents, access to examine, audit, and copy any and all records deemed by Molina, in Molina's sole discretion, necessary to determine compliance with the terms of the Provider Agreement, including for the purpose of investigating potential fraud, waste and abuse. Documents and records must be readily accessible at the location where Provider provides services to any Molina members. Auditable documents and records include, but are not limited to, medical charts; patient charts; billing records; and coordination of benefits information. Production of auditable documents and records must be provided in a timely manner, as requested by Molina and without charge to Molina. In the event Molina identifies fraud, waste or abuse, Provider agrees to repay funds or Molina may seek recoupment.

If a Molina auditor is denied access to Provider's records, all of the claims for which Provider received payment from Molina is immediately due and owing. If Provider fails to provide all requested documentation for any claim, the entire amount of the paid claim is immediately due and owing. Molina may offset such amounts against any amounts owed by Molina to Provider. Provider must comply with all requests for documentation and records timely (as reasonably requested by Molina) and without charge to Molina. Claims for which Provider fails to furnish supporting documentation during the audit process are not reimbursable and are subject to chargeback.

Provider acknowledges that HIPAA specifically permits a covered entity, such as Provider, to disclose protected health information for its own payment purposes (see 45 CFR 164.502 and 45 CFR 154.501). Provider further acknowledges that in order to receive payment from Molina, Provider is required to allow Molina to conduct audits of its pertinent records to verify the services performed and the payment claimed, and that such audits are permitted as a payment activity of Provider under HIPAA and other applicable privacy laws.

J. Reporting Fraud, Waste and Abuse

If you suspect cases of fraud, waste or abuse, you must notify Molina's Compliance department – **see Section C above**. You have the right to report your concerns anonymously without fear of retaliation. Information reported to Compliance will remain confidential to the extent possible as allowed by law.

When reporting an issue, please provide as much information as possible. The more information provided, the better the chances the situation will be successfully reviewed and resolved. Information that should be reported includes:

- Allegation – A complete description of the allegation, including the type of fraud, waste, or abuse (e.g., balance billing, falsification of information, billing for services not rendered).
- Suspect's Identity - The names, including any aliases or alternative names, of individuals and/or entity involved in suspected fraud and/or abuse including address, telephone number, email address, Medicare and/or Medicaid ID number and any other identifying information.
- Dates of Occurrence – When did the fraud, waste, or abuse happen? Provide dates and times.

XIII. Credentialing and Recredentialing

The purpose of the Credentialing Program is to strive to assure that the Molina Healthcare, Inc. and its subsidiaries (Molina) network consists of quality practitioners who meet clearly defined criteria and standards. It is the objective of Molina to provide superior health care to the community.

The decision to accept or deny a credentialing applicant is based upon primary source verification, secondary source verification, recommendation of peer practitioners and additional information as required. The information gathered is confidential and disclosure is limited to parties who are legally permitted to have access to the information under state and federal law.

The Credentialing Program has been developed in accordance with state and federal requirements and the standards of the National Committee for Quality Assurance (NCQA). The Credentialing Program is reviewed annually and revised and updated as needed.

A. Criteria for Participation in the Molina Network

Molina has established criteria and the sources used to verify these criteria for the evaluation and selection of practitioners for participation in the Molina network. This policy defines the criteria that are applied to applicants for initial participation, recredentialing and ongoing participation in the Molina network.

Molina reserves the right to exercise discretion in applying any criteria and to exclude practitioners who do not meet the criteria. To remain eligible for participation practitioners must continue to satisfy all applicable requirements for participation as stated herein and in all other documentations provided by Molina.

Practitioners should adhere strictly to the ethics of the profession, have demonstrated a temperament and ability to work cooperatively with others free of evidence of a disruptive personality, and be willing to participate in the provision of cost effective and quality services in the managed care environment, including but not limited to the discharge of Molina responsibilities.

Practitioners must meet the following criteria to be eligible to participate in the Molina network. If the practitioner fails to provide proof of meeting these criteria, the credentialing application will be deemed incomplete and it will result in an administrative denial or termination from the Molina network. Practitioners who fail to provide proof of meeting these criteria do not have the right to submit an appeal.

1. Practitioner must practice, or plan to practice within 90 calendar days, within the area served by Molina.
2. Practitioner must have a current, valid license to practice in their specialty in every state in which they will provide care for Molina members.

3. Practitioner must have current professional malpractice liability coverage with limits that meet Molina criteria.
4. If applicable to the specialty, practitioner must have a current and unrestricted federal Drug Enforcement Agency (DEA) certificate and Controlled Substance Certification or Registration.
5. Dentists, Oral Surgeons, Physicians (MDs, DOs) and Podiatrists will only be credentialed in an area of practice in which they have adequate training as outlined below. Therefore, they must confine their practice to their credentialed area of practice when providing service to Molina members. Adequate training must be demonstrated by one of the following:
 - a. Current Board Certification by a board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the American Dental Association in the credentialed area of practice, the American Board of Podiatric Surgery, the American Board of Podiatric Orthopedic and Primary Medicine (ABPOPM), or the American Board of Oral and Maxillofacial Surgery
 - b. Successful completion of a residency or fellowship program accredited by the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA) in the United States or by the College of Family Physicians in Canada (CFPC) or the Royal College of Physicians and Surgeons of Canada. Oral Surgeons must complete a training program in Oral and Maxillofacial Surgery accredited by the Commission on Dental Accreditation (CODA).
 - c. Practitioners who are not Board Certified as described in section 5a above and have not completed an accredited Residency program are only eligible to be considered for participation as a General Practitioner in the Molina network. To be eligible as a General Practitioner, the practitioner must have maintained a primary care practice in good standing for a minimum of the most recent five years without any gaps in work history.
6. At the time of initial application, the practitioner must not have any pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action or the equivalent from any state or governmental professional disciplinary body. If a practitioner's application is denied solely because a practitioner has a pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action or the equivalent from any state or governmental professional disciplinary body, the practitioner may reapply as soon as practitioner is able to demonstrate that any pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action, or the equivalent from any state or governmental professional disciplinary body is resolved, even if the application is received less than one year from the date of original denial.

7. Practitioner must not be currently excluded, expelled or suspended from any state or federally funded program including but not limited to the Medicare or Medicaid programs.
8. Practitioner must not have been convicted of a felony or pled guilty to a felony for a healthcare related crime including but not limited to healthcare fraud, patient abuse and the unlawful manufacture distribution or dispensing of a controlled substance.
9. Practitioners not able to practice independently according to state law (e.g. NP's, Midwives, PA-C's) must have a practice plan with a supervising physician approved by the state licensing agency. The supervising physician must be contracted and credentialed with Molina.
10. Physicians, Primary Care Practitioners, Midwives, Oral Surgeons and Podiatrists must have admitting privileges in their specialty or have a plan for hospital admission by using a Hospital Inpatient Team or having an arrangement with a credentialed Molina participating practitioner that has the ability to admit Molina patients to a hospital. Practitioners practicing exclusively on a consultative basis are not required to have admitting hospital privileges.
11. Licensed midwives who perform deliveries outside of an acute care hospital must have a formal arrangement in place with an OB/GYN contracted and credentialed with Molina Healthcare. This arrangement must include 24-hour coverage and inpatient care for Molina members in the event of emergent situations. Family Practitioners providing obstetric care may provide the back-up in rural areas that do not have an OB/Gyn. This back-up physician must be located within 30 minutes from the midwives practice.
12. If applicable to the specialty, practitioner must have a plan for shared call coverage that includes 24-hours a day, seven days per week and 365 days per year. The covering practitioner(s) must be qualified to assess over the phone if a patient should immediately seek medical attention or if the patient can wait to be seen on the next business day.
13. Molina may determine, in its sole discretion, that a practitioner is not eligible to apply for network participation if the practitioner is an employee of a practitioner or an employee of a company owned in whole or in part by a practitioner, who has been denied or terminated from network participation by Molina, who is currently in the Fair Hearing Process, or who is under investigation by Molina. Molina also may determine, in its sole discretion that a practitioner cannot continue network participation if the practitioner is an employee of a practitioner or an employee of a company owned in whole or in part by a practitioner, who has been denied or terminated from network participation by Molina. For purposes of this criteria, a company is "owned" by a practitioner when the practitioner has a majority financial interest in the company, through shares or other means.
14. Practitioners denied or terminated by the Credentialing Committee are not eligible to reapply until one year after the date of denial or termination by the Credentialing

Committee. At the time of reapplication, practitioner must meet all criteria for participation as outlined above.

B. Burden of Proof

The practitioner shall have the burden of producing adequate information to prove he/she meets all criteria for initial participation and continued participation in the Molina network. This includes but is not limited to proper evaluation of their experience, background, training, demonstrated ability and ability to perform as a practitioner without limitation, including physical and mental health status as allowed by law, and the burden of resolving any doubts about these or any other qualifications to participate in the Molina network. If the practitioner fails to provide this information, the credentialing application will be deemed incomplete and it will result in an administrative denial or termination from the Molina network. Practitioners who fail to provide this burden of proof do not have the right to submit an appeal.

C. Practitioner termination and reinstatement

If a practitioner's contract is terminated and later it is determined to reinstate the practitioner, the practitioner must be initially credentialed prior to reinstatement if there is a break in service more than 30 calendar days. The credentialing factors that are no longer within the credentialing time limits and those that will not be effective at the time of the Credentialing Committee's review must be re-verified. The Credentialing Committee or medical director, as appropriate, must review all credentials and make a final determination prior to the practitioner's reentry into the network. Not all elements require re-verification; for example, graduation from medical school or residency completion does not change.

If a practitioner is given administrative termination for reasons beyond Molina's control (e.g., the practitioner failed to provide complete credentialing information), and is then reinstated within 30 calendar days, Molina may recredential the practitioner as long as there is clear documentation that the practitioner was terminated for reasons beyond Molina's control and was recredentialled and reinstated within 30 calendar days of termination. Molina must initially credential the practitioner if reinstatement is more than 30 calendar days after termination.

If Molina is unable to recredential a practitioner within 36-months because the practitioner is on active military assignment, maternity leave or sabbatical; but the contract between Molina and the practitioner remains in place, Molina will recredential the practitioner upon his or her return. Molina will document the reason for the delay in the practitioner's file. At a minimum, Molina will verify that a practitioner who returns has a valid license to practice before he or she can resume seeing patients. Within 60 calendar days of notice when the practitioner resumes practice, Molina will complete the recredentialing cycle. If either party terminates the contract and there is a break in service of more than 30 calendar days, Molina will initially credential the practitioner before the practitioner rejoins the network.

D. Practitioners terminating with a delegate and contracting with Molina directly

Practitioners credentialed by a delegate who terminate their contract with the delegate and want to contract with Molina directly must be credentialed by Molina within six-months of the practitioner's termination with the delegate. If the practitioner has a break in service more than 30 calendar days, the practitioner must be initially credentialed prior to reinstatement.

E. Credentialing Application

At the time of initial credentialing and recredentialing, the practitioner must complete a credentialing application designed to provide Molina with information necessary to perform a comprehensive review of the practitioner's credentials. The application must be completed in its entirety. The practitioner must attest that their application is complete and correct within 180 calendar days of the credentialing decision. The application must be completed in typewritten text, in pen or electronically through applications such as the Counsel for Affordable Quality Healthcare (CAQH) Universal Credentialing Data Source. Pencils or erasable ink will not be an acceptable writing instrument for completing credentialing applications. Molina may use another organization's application as long as it meets all the factors outlined in this policy. Molina will accept faxed, digital, electronic, scanned or photocopied signatures. A signature stamp is not acceptable on the attestation. The attestation must include:

- Reason for any inability to perform the essential functions of the position, with or without accommodation;
- Lack of present illegal drug use;
- History of loss of license and felony convictions;
- History of loss or limitation of privileges or disciplinary action;
- Current malpractice insurance coverage; and
- The correctness and completeness of the application.

Inability to perform essential functions and illegal drug use - An inquiry regarding illegal drug use and inability to perform essential functions may vary. Practitioners may use language other than "drug" to attest they are not presently using illegal substances. Molina may accept more general or extensive language to query practitioners about impairments; language does not have to refer exclusively to the present, or only to illegal substances.

History of actions against applicant - An application must contain the following information:

- History of loss of license;
- History of felony convictions; and
- History of all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which a practitioner has had privileges.

Current malpractice coverage - The application form must include specific questions regarding the dates and amount of a practitioner's current malpractice insurance. Molina may obtain a copy of the insurance face sheet from the malpractice carrier in lieu of collecting the information in the application.

For practitioners with federal tort coverage, the application need not contain the current amount of malpractice insurance coverage. Practitioner files that include a copy of the federal tort letter or an attestation from the practitioner of federal tort coverage are acceptable.

Correctness and completeness of the application - Practitioners must attest that their application is complete and correct when they apply for credentialing and recredentialing. If a copy of an application from an entity external to Molina is used, it must include an attestation to the correctness and completeness of the application. Molina does not consider the associated attestation elements as present if the practitioner did not attest to the application within the required time frame of 180 days. If state regulations require Molina to use a credentialing application that does not contain an attestation, Molina must attach an addendum to the application for attestation.

Meeting Application time limits - If the practitioner attestation exceeds 180 days before the credentialing decision, the practitioner must attest that the information on the application remains correct and complete, but does not need to complete another application. It is preferred to send a copy of the completed application with the new attestation form when requesting the practitioner to update the attestation.

F. Office Site and Medical Record Keeping Practices Review

A review of office sites where you see Molina Members may be required. This review may be scheduled as soon as the Credentialing Department receives your application. This may also include a review of your medical record keeping practices. A passing score is required to complete the application process. Your cooperation in working with the site review staff and implementing any corrective action plans will expedite a credentialing decision.

Office site and medical record keeping reviews may also be initiated if any member complaints are received regarding the physical accessibility, physical appearance or adequacy of waiting room and examining room space.

G. The Process for Making Credentialing Decisions

All practitioners requesting initial participation with Molina must complete a credentialing application. To be eligible to submit an application, practitioners must meet all the criteria outlined above in the section titled “Criteria for Participation in the Molina Network”. Practitioners may not provide care to Molina members until the final decision is rendered by the Credentialing Committee or the Molina Medical Director.

Molina recredentials its practitioners at least every thirty-six (36) months. Approximately six months prior to the recredentialing due date, a request will be sent to the practitioner requesting completion of a recredentialing application.

During the initial and recredentialing application process, the practitioner must:

- Submit a completed application within the requested timeframe
- Attest to the application within the last 180 calendar days
- Provide Molina adequate information to prove he/she meets all criteria for initial participation or continued participation in the Molina network.

Once the application is received, Molina will complete all the verifications as outlined in the Credentialing Program Policy. In order for the application to be deemed complete, the practitioner must produce adequate information to prove he/she meets all criteria for initial participation or continued participation in the Molina network. All fields within the application must be completed, all required attachments must be included, detailed explanations must be provided to all affirmative answers on the attestation questions and any additional information requested by Molina must be provided.

If the practitioner does not provide the information necessary to complete the application process in the time period requested, the application will be deemed incomplete and Molina will discontinue processing of the application. This will result in an administrative denial or termination from the Molina network. Practitioners who fail to provide proof of meeting criteria or fail to provide a complete credentialing application do not have the right to submit an appeal.

At the completion of the application and primary source verification process, each credentialing file is quality reviewed to ensure completeness. During this quality review process each credentialing file is assigned a level based on specific Credentialing Review Guidelines. Credentialing files assigned a level 1 are considered clean credentialing files and the Medical Director(s) responsible for credentialing has the authority to review and approve them. Credentialing files assigned a level 2 are reviewed by the Molina Credentialing Committee. The Medical Director has the right to request the Credentialing Committee review any credentials file. The Credentialing Committee has the right to request to review any credentials file.

H. Credentialing Committee

Molina maintains a Credentialing Committee made up of other practitioners practicing in the community who make recommendations regarding credentialing decision using a peer review process. Once a credentials file contains all the necessary information it will be submitted for approval to the Credentialing Committee. If the Credentialing Committee determines further information is necessary to evaluate a provider's application, the Credentialing Department will request such information on behalf of the Credentialing Committee. Molina works with the Credentialing Committee to strive to assure that network practitioners are competent and qualified to provide continuous quality care to Molina members. A practitioner may not provide care to Molina members until the final decision from the

Credentialing Committee or in situations of “clean files” the final decision from the Molina Medical Director.

The Governing Board of Molina has delegated the authority to approve and to deny applicants to the Credentialing Committee. The Credentialing Committee is required to meet no less than quarterly, but generally meets on a monthly basis, to facilitate timely processing of applicant files.

I. Delegating Credentialing and Recredentialing

Molina will delegate credentialing and recredentialing activities to Independent Practice Associations (IPA), Provider Groups and other delegated entities that meet Molina’s requirements for delegation. Molina’s Delegation Oversight Committee (DOC) must approve all delegation and subdelegation arrangements, and retains the right to limit or revoke any and all delegated credentialing activities when a delegate fails to meet Molina’s requirements.

Molina’s Credentialing Committee retains the right to approve new providers and provider sites and terminate practitioners, providers and sites of care based on requirements in Molina Credentialing Policy.

To be delegated for credentialing, IPAs, Provider Groups and other delegated entities must:

- Be National Committee for Quality Assurance (NCQA) accredited or certified for credentialing or pass Molina’s credentialing delegation pre-assessment, which is based on NCQA credentialing standards and requirements for the Medicaid and Medicare programs, with a score of at least 90%.
- Correct deficiencies within mutually agreed upon time frames when issues of non-compliance are identified by Molina at pre-assessment
- Agree to Molina’s contract terms and conditions for credentialing delegates
- Submit timely and complete reports to Molina as described in policy and procedure
- Comply with all applicable federal and state laws
- If the IPA or Provider Group subdelegates primary source verification to a Credentialing Verification Organization (CVO), the CVO must be NCQA certified in all ten areas of accreditation.

J. Non-Discrimination

Molina does not make credentialing and recredentialing decisions based on an applicant’s race, ethnic/national identity, gender, age, sexual orientation or the types of procedures (e.g. abortions) or patients (e.g. Medicaid or Medicare) in which the practitioner specializes. This does not preclude Molina from including in its network practitioners who meet certain demographic or specialty needs; for example, to meet cultural needs of members.

Prevention - Molina takes appropriate steps to protect against discrimination occurring in the credentialing and recredentialing processes. Molina maintains a heterogeneous credentialing committee membership. It is also required that each committee member sign an affirmative statement annually to make decisions in a nondiscriminatory manner.

Monitoring - Every six months, Molina pulls credentialing data to show all credentialing decisions made and looks at a breakdown of types of decisions by provider's gender and age. This data is compiled into a report and presented to the Compliance Committee. The Compliance Committee reviews the report to ensure there are no obvious trends in discrimination when making credentialing decisions. Molina does not ask for providers' race or ethnicity in the credentialing process so this information is unknown when decisions are made.

If Molina receives any complaint regarding alleged discrimination, the complaint is thoroughly investigated and the results of the investigation are forwarded to the Molina legal department for review and determination.

K. Notification of Discrepancies in Credentialing Information

Molina will notify the practitioner immediately in writing in the event that credentialing information obtained from other sources varies substantially from that provided by the practitioner. Examples include but are not limited to actions on a license; malpractice claims history or board certification decisions. Molina is not required to reveal the source of information if the information is not obtained to meet organization credentialing verification requirements or if disclosure is prohibited by law. Please also refer to the section below titled Practitioners Right to Correct Erroneous Information.

L. Notification of Credentialing Decisions

A letter is sent to every practitioner with notification of the Credentialing Committee or Medical Director decision regarding their participation in the Molina network. This notification is sent within two weeks of the decision. Copies of the letters are filed in the practitioner's credentials files. Under no circumstance will notifications letters be sent to the practitioners later than 60 calendar days from the decision.

M. Confidentiality

All practitioner information obtained during the credentialing process is private and confidential except where otherwise specified by law or at the discretion of the Credentialing Committee or the Molina Board. This policy includes both voting and non-voting members of the Credentialing Committee, invited guests of the Credentialing Committee and Molina Credentialing staff who is involved in the data collection and file preparation for the credentialing and recredentialing process.

Information, documents and/or evidence created, collected, maintained or otherwise arising out of matters that are under review, or have been reviewed pursuant to these policies, will be kept confidential by all participants except as required by law or at the discretion of the Credentialing Committee or the Molina Board, in order to encourage candor and careful assessment necessary to effect peer review and quality assurance.

All members (voting and non-voting) and guests of the Credentialing Committee, or any other committee performing any peer review functions or other individuals who participate in peer review functions will sign a Statement of Confidentiality annually. Members and guests of the Credentialing Committee will not discuss, share or use any information for any purpose other than peer review at Molina.

The Director in charge of Credentialing grants access to electronic credentials files only as necessary to complete credentialing work or as required by law. Access to these documents are restricted to authorized staff, Credentialing Committee members, peer reviewers and reporting bodies as authorized by the Credentialing Committee or the Governing Board of Molina. Each person is given a unique user ID and password. It is the strict policy of Molina that employees keep their passwords confidential and never share their passwords with anyone. All Credentialing employees are prompted to change their passwords into the system every three-months.

Minutes, reports and files of Credentialing Committee meetings are stored in secure electronic folders or in locked cabinets in the Credentialing Department and will be protected from discovery under all applicable laws.

Copies of minutes and any other related Credentialing Committee meeting materials will not be allowed to be removed from meetings of peer review committees and Credentialing staff will shred extra sets of information from such meetings. Electronic data and/or information are password protected and Molina Staff is instructed not to divulge passwords to their co-workers.

N. Providers' Rights during the Credentialing Process

1. Providers have the right to review their credentialing file.

Providers have the right to review their credentialing file at any time. The provider must notify the Credentialing Department and request an appointed time to review their file and allow up to seven (7) calendar days to coordinate schedules. A Medical Director and the Quality Improvement Director will be present. The provider has the right to review all information in the credentials file except peer references or recommendations protected by law from disclosure.

The only items in the file that may be copied are the application, the license and the DEA certificate. Providers may not copy documents that include pieces of information that are confidential in nature, such as the provider credentialing checklist, the responses from monitoring organizations (e.g., National Provider Data Bank, State Licensing Board), and verification of hospital privileges letters.

2. Providers have the right to correct erroneous information.

Practitioners have the right to correct erroneous information in their credentials file. Practitioners are notified of their right in a letter sent to them at the time the initial or recredentialing application is received.

Molina will notify the practitioner immediately in writing in the event that credentialing information obtained from other sources varies substantially from that provided by the practitioner. Examples include but are not limited to actions on a license or malpractice claims history. Molina is not required to reveal the source of information if the information is not obtained to meet organization credentialing verification requirements or if disclosure is prohibited by law.

The notification sent to the practitioner will detail the information in question and will include instructions to the practitioner indicating:

- Their requirement to submit a written response within 10 calendar days of receiving notification from Molina.
- In their response, the practitioner must explain the discrepancy, may correct any erroneous information and may provide any proof that is available.
- The practitioner's response must be sent to Molina Healthcare, Inc. Attention Kari Horseman, CPCS, Credentialing Director at PO Box 2470 Spokane WA 99210

Upon receipt of notification from the practitioner, Molina will document receipt of the information in the practitioners credentials file. Molina will then re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the practitioners credentials file. The practitioner will be notified in writing that the correction has been made to their credentials file. If the primary source information remains inconsistent with practitioners' notification, the Credentialing Department will notify the practitioner. The practitioner may then provide proof of correction by the primary source body to Molina's Credentialing Department. The Credentialing Department will re-verify primary source information if such documentation is provided.

If the practitioner does not respond within 10 calendar days, their application processing will be discontinued and network participation will be denied.

3. Providers' right to be informed of their application status.

Practitioners have a right, upon request, to be informed of the status of their application. Practitioners applying for initial participation are sent a letter when their application is received by Molina and are notified of their right to be informed of the status of their application in this letter. Practitioners are also notified of their right in the Provider Manual sent to them at the time of initial contracting.

The practitioner can request to be informed of the status of their application by telephone, email or mail. Molina will respond to the request within two working days. Molina may share with the practitioner where the application is in the credentialing process to include any missing information or information not yet verified. Molina does not share with or allow a practitioner to review references or recommendations, or other information that is peer-review protected.

O. Ongoing Monitoring Between Credentialing Cycles

Molina monitors for complaints, sanctions, adverse actions, disciplinary actions and malpractice cases between credentialing cycles for all practitioner types. When new information is received between recredentialing cycles, the practitioner will be immediately placed into the full credentialing process and will be recredentialed early. The practitioner must provide all necessary information to complete the recredentialing process within the requested time-frames or the practitioner will be administratively terminated from the network. The complete recredentialing file will be reviewed at the next scheduled Credentialing Committee meeting for a determination. Molina takes appropriate action against practitioners when occurrences of poor quality are identified.

P. Excluded Providers

Excluded provider means an individual provider, or an entity with an officer, director, agent, manager or individual who owns or has a controlling interest in the entity who has been: convicted of crimes as specified in section 1128 of the SSA, excluded from participation in the Medicare or Medicaid program, assessed a civil penalty under the provisions of section 1128, or has a contractual relationship with an entity convicted of a crime specified in section 1128.

Pursuant to section 1128 of the SSA, Molina Medicare and its subcontractors may not subcontract with an Excluded Provider/Person. Molina Medicare and its subcontractors shall terminate subcontracts immediately when Molina Medicare and its subcontractors become aware of such excluded provider/person or when Molina Medicare and its subcontractors receive notice. Molina Medicare and its subcontractors certify that neither it nor its member/provider is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency. Where Molina Medicare and its subcontractors are unable to certify any of the statements in this certification, Molina Medicare and its subcontractors shall attach a written explanation to this Agreement.

Q. Providers opting out of Medicare

If a provider opts out of Medicare, that provider may not accept Federal reimbursement for a period of two (2) years. Providers who are currently opted out of Medicare are not eligible to contract with Molina for the Medicare line of business.

R. Credentialing Committee Range of Actions, Notification to Authorities and Practitioner Appeal Rights

Molina uses established criteria in the review of practitioners' performance. All adverse actions taken by the Credentialing Committee are conducted in compliance with the Fair Hearing Plan and the Healthcare Quality Improvement Act of 1986.

Range of actions available

The Molina Credentialing Committee can take one of the following actions against practitioners who fail to meet credentialing standards or who fail to meet performance expectations pertaining to quality of patient care:

- Monitor on a Watch Status
- Require formal corrective action
- Denial of network participation
- Termination from network participation
- In cases where the Medical Director determines the circumstances pose an immediate risk to patients, a practitioner may be summarily suspended from participation in the network, without prior notice, pending review and investigation of information relevant to the case.

This applies to all practitioners who are contracted by Molina. These actions do not apply to applicants who do not meet basic conditions of participation and are ineligible for participation. The purpose of this policy is to provide a mechanism for implementation of monitoring on watch status, requiring formal corrective action, suspension or termination of Molina practitioners.

If at any point a practitioner fails to meet the minimum standards and criteria for credentialing or fails to meet performance expectations with regard to quality of patient care the Credentialing Committee may act to implement one of these actions. Termination may be taken after reasonable effort has been made to obtain all the facts of the matter and the practitioner may be given the opportunity to appeal this decision.

Criteria for Denial or Termination Decisions by the Credentialing Committee

The criteria used by the Credentialing Committee to make a decision to deny or terminate a practitioner from the Molina network include, but are not limited to, the following:

1. The practitioner's professional license in any state has ever had any informal or formal disciplinary orders, decisions, agreements, disciplinary actions or other actions including but not limited to, restrictions, probations, limitations, conditions suspensions and revocations.
2. Practitioner has ever surrendered, voluntarily or involuntarily, his or her professional license in any State while under investigation by the State or due to findings by the State resulting from the practitioner's acts, omissions or conduct.
3. Practitioner has any pending statement of charges, notice of proposed disciplinary actions, notice of agency action or the equivalent from any state or governmental professional disciplinary body which based on the judgment of the Credentialing Committee establishes an immediate potential risk to the quality of care or service delivered by the practitioner to Molina members.

4. Practitioner has ever had any restrictions, probations, limitations, conditions, suspensions or revocations on their federal Drug Enforcement Agency (DEA) certificate or Controlled Substance Certification or Registration.
5. Practitioner has a condition, restriction or limitation on their license, certification or registration related to an alcohol, chemical dependency, or health condition or if other evidence indicates that the practitioner has an alcohol, chemical dependency problem or health condition and there is no clear evidence and documentation demonstrating that the practitioner has complied with all such conditions, limitations, or restrictions and is receiving treatment adequate to ensure that the alcohol, chemical dependency problem or health condition will not affect the quality of the practitioner's practice.
6. Practitioner has ever had sanctions of any nature taken by any governmental program or professional body including but not limited to, Medicare, Medicaid, Federal Employee Program or any other State or Federal program or agency
7. Practitioner has ever had any denials, limitations, suspensions or terminations of participation of privileges by any health care institution, plan, facility or clinic.
8. Practitioner's history of medical malpractice claims or professional liability claims or settlements reflect what constitutes a pattern of questionable or inadequate treatment or contain what constitutes any gross or flagrant incident or incidents of malpractice.
9. Practitioner has a criminal history, including, but not limited to, any criminal charges, criminal investigations, convictions, no-contest pleas and guilty pleas.
10. Practitioner has ever had involvement in acts of dishonesty, fraud, deceit or misrepresentation that relate to or impact or could relate to or impact the practitioner's professional conduct or the health, safety or welfare of Molina members
11. Practitioner has ever engaged in acts which Molina, in its sole discretion, deems inappropriate.
12. Practitioner has a pattern of member complaints or grievances in which there appears to be a concern regarding the quality of service provided to Molina members.
13. Practitioner has not complied with Molina's quality assurance program.
14. Practitioner is found to have rendered a pattern of substandard care or is responsible for any gross or flagrant incident of substandard care.
15. Practitioner has displayed inappropriate patterns of referral, which deviate substantially from reasonably expected patterns of referral.
16. Practitioner makes any material misstatements in or omissions from their credentialing application and attachments.

17. Practitioner has ever rendered services outside the scope of their license.
18. Practitioner has a physical or mental health condition that may impair their ability to practice with the full scope of licensure and qualifications, or might pose a risk of harm on patients.
19. Practitioner's failure to comply with the Molina Medical Record Review Guidelines.
20. Practitioner's failure to comply with the Molina Site Review or Medical Record Keeping Practice Review Guidelines.

Monitoring on a Committee Watch Status

Molina uses the credentialing category "watch status" for practitioners whose initial or continued participation is approved by the Credentialing Committee with follow-up to occur. The Credentialing Committee may approve a practitioner to be monitored on watch status when there are unresolved issues or when the Credentialing Committee determines that the practitioner needs to be monitored for any reason.

When a practitioner is approved on watch status, the Credentialing Department conducts the follow-up according to the Credentialing Committee direction. Any unusual findings are reported immediately to the Molina Medical Director to determine if immediate action is necessary. Every unusual finding is reviewed in detail at the next Credentialing Committee meeting for review and determination.

Corrective Action

In cases where altering the conditions of participation is based on issues related to quality of care and/or service, Molina may work with the practitioner to establish a formal corrective action plan to improve performance, prior to, or in lieu of suspending or terminating his or her participation status.

A corrective action plan is a written improvement plan, which may include, but is not limited to the following:

- Identifying the performance issues that do not meet expectations
- What actions/processes will be implemented for correction
- Who is responsible for the corrective action
- What improvement/resolution is expected
- How improvements will be assessed
- Scheduled follow-up, monitoring (compliance review, normally not to exceed six months)

Practitioners subject to corrective action will be notified within ten (10) calendar days, via a certified letter from the Medical Director. Such notification will outline:

- The reason for the corrective action

- The corrective action plan

If the corrective actions are resolved, the practitioner's performance may or may not be monitored, as deemed appropriate. If the corrective action(s) are not adequately resolved within the designated time, depending on the circumstances of the case, the Credentialing Committee may recommend that the practitioner continue on an improvement plan, or recommend suspension or termination. All recommendations for termination that result from a lack of appropriate practitioner response to corrective action will be brought to the Credentialing Committee for review and decision.

Summary Suspension

In cases where the Medical Director becomes aware of circumstances that pose an immediate risk to patients, a meeting will be held immediately with Molina Legal Counsel, the Medical Director and the Director of Credentialing. After discussing the facts, the practitioner may be summarily suspended from participation in the network, without prior notice, pending review and investigation of information relevant to the case.

Such summary suspension shall become effective immediately upon imposition, and the Medical Director shall promptly notify the practitioner of the suspension, via a certified letter. Notification will include the following:

- The action being taken
- Effective date of the action
- The reason(s) for the action and/or information being investigated
- Information (if any) required from the practitioner
- The estimated timeline for determining whether or not to reinstate or terminate the practitioner
- Details regarding the practitioners right to request a fair hearing within 30 calendar days (see Fair Hearing Plan policy) and their right to be represented by an attorney or another person of their choice

Upon initiation of the suspension, the Medical Director and credentialing staff will commence investigation of the issues. Findings of the investigation will be presented to the Credentialing Committee. The Credentialing Committee has the authority to implement corrective action, place conditions on the practitioner's continued participation, discontinue the suspension or terminate the practitioner.

Termination

After review of appropriate information, the Credentialing Committee may determine that the practitioner does not meet performance expectations pertaining to quality of care, services or established performance/professional standards. The Credentialing Committee may then vote to terminate the practitioner. The effective date of the termination is determined by the contractual agreement between Molina and the affected practitioner.

Within five working days after the Credentialing Committee makes a recommendation to terminate a practitioner, the Medical Director, Molina Legal Counsel and the Corporate

Credentialing Director will meet to review the details regarding the Credentialing Committee's decision to terminate the practitioner and to draft the written notification to the practitioner.

Within ten (10) calendar days of the Committee's decision, the practitioner is sent written notice of termination, via a certified letter from the Medical Director, which includes the following:

- Effective date of termination
- Reason for termination
- Obligations of the practitioner regarding further care of Molina patients/members
- If applicable, details regarding the practitioners right to request a fair hearing within 30 calendar days (see Fair Hearing Plan policy) and their right to be represented by an attorney or another person of their choice

Notification to Authorities

Molina will make reports to appropriate authorities as specified in the Fair Hearing Plan Policy when the Credentialing Committee takes or recommends certain Adverse Actions for a Practitioner based upon Unprofessional Conduct including:

- Revocation, termination of, or expulsion from Molina Provider status.
- Summary Suspension in effect or imposed for more than thirty (30) calendar days.
- Any other final action by Molina that by its nature is reportable to the State Licensing Board, the NPDB, and/or HIPDB.

If a Fair Hearing is offered, a certified letter is sent to the practitioner describing the adverse action taken, the reason for the action and notifying the practitioner of their right to a Fair Hearing. A copy of the Fair Hearing Plan Policy is included with the letter. The practitioner is given 30 calendar days to request a Fair Hearing. The practitioner is notified of their right to be represented by an attorney or another person of their choice.

If the practitioner requests a Fair Hearing, the Molina Fair Hearing Plan Policy is followed. A hearing officer is appointed and a panel of individuals appointed by Molina to review the appeal. Once the hearing is completed, a written notification of the appeal decision will be sent to the practitioner which will contain the specific reason for the decision.

Within 15 calendar days of the effective date of the action, the Manager responsible for credentialing reports the action to the following authorities:

- All appropriate state licensing agencies
- National Practitioner Data Bank (NPDB) and Healthcare Integrity and Protection Data Bank (HIPDB)

A letter is then written to the appropriate state licensing boards describing the adverse action taken, the practitioner it was taken against and a copy of the NPDB/HIPDB report is attached to the letter. This letter is sent certified to the appropriate state licensing boards within 24-

hours of receiving the final NPDB/HIPDB report. A copy of this letter is filed into the Practitioner's credentials file.

S. Fair Hearing Plan Policy

Molina Healthcare, Inc., and its affiliates ("Molina"), will maintain and communicate the process providing procedural rights to Providers when a final action by Molina will result in a report to the State Licensing Board, NPDB, and/or HIPDB.

1. Definitions

- a) Adverse Action shall mean an action that entitles a Provider to a hearing, as set forth in Section B (1)-(3) below.
- b) Chief Medical Officer shall mean the Chief Medical Officer for the respective Molina affiliate state plan wherein the Provider is contracted.
- c) Days shall mean calendar days. In computing any period of time prescribed or allowed by this Policy, the day of the act or event from which the designated period of time begins shall not be included.
- d) Medical Director shall mean the Medical Director for the respective Molina affiliate state plan wherein the Provider is contracted.
- e) Molina Plan shall mean the respective Molina affiliate state plan wherein the Provider is contracted.
- f) Notice shall mean written notification sent by certified mail, return receipt requested, or personal delivery.
- g) Peer Review Committee or Credentialing Committee shall mean a Molina Plan committee or the designee of such a committee.
- h) Plan President shall mean the Plan President for the respective Molina affiliate state plan wherein the Provider is contracted.
- i) Provider shall mean physicians, dentists, and other health care practitioners as defined by 42 USC 11151 and Social Security Act § 1861(u).
- j) State shall mean Molina Healthcare of Washington, Inc.
- k) State Licensing Board shall mean the state agency responsible for the licensure of Provider.
- l) Unprofessional Conduct refers to a basis for corrective action or termination involving an aspect of a Provider's competence or professional conduct which is reasonably likely to be detrimental to patient safety or the delivery of quality care.

Unprofessional conduct does not refer to instances where a Provider violates a material term of the Provider's contract with a Molina Plan.

2. Grounds for a Hearing

Grounds for a hearing exist whenever the Peer Review Committee or Credentialing Committee takes or recommends any of the following Adverse Actions for a Provider based upon Unprofessional Conduct:

- a) Revocation, termination of, or expulsion from Molina Provider status when such revocation, termination, or expulsion is reportable to the State Licensing Board, NPDB, and/or HIPDB.
- b) Suspension, reduction, limitation, or revocation of authority to provide care to Molina members.
- c) Any other final action by Molina that by its nature is reportable to the State Licensing Board, NPDB, and/or HIPDB.

3. Notice of Action

If the Peer Review Committee and/or Credentialing Committee have recommended an Adverse Action, the Committee shall give written notice to the Provider by certified mail with return receipt requested. The notice shall:

- a) State the reasons for the action;
- b) State any Credentialing Policy provisions that have been violated;
- c) Advise the Provider that he/she has the right to request a hearing on the proposed Adverse Action;
- d) Advise the Provider that any request for hearing must be made in writing within thirty (30) days following receipt of the Notice of Action, and must be sent to the respective Molina Plan Medical Director by certified mail, return receipt requested, or personal delivery;
- e) Advise the Provider that he/she has the right to be represented by an attorney or another person of their choice.
- f) Advise the Provider that the request for a hearing *must* be accompanied by a check in the amount of \$1,000.00 as a deposit for the administrative expenses of the hearing and specify that this amount will be refunded if the Adverse Action is overturned;
- g) State that the proposed action or recommendation, if adopted, must be reported pursuant to State and Federal law; and
- h) Provide a summary of the Provider's hearing rights or attach a copy of this Policy.

4. Request for a Hearing - Waiver

If the Provider does not request a hearing in writing to the Chief Medical Officer within thirty (30) days following receipt of the Notice of Action, the Provider shall be deemed to have accepted the action or recommendation of the Peer Review Committee and/or Credentialing Committee, and such action or recommendation shall be submitted to the Chief Medical Officer for final decision. In the event that a timely written Request for Hearing is received, a Hearing Officer and/or hearing panel shall be appointed as set forth below and the Peer Review Committee and/or Credentialing Committee shall provide the Provider with a Notice of Hearing and Statement of Charges consistent with this Policy.

A Provider who fails to request a hearing within the time and in the manner specified above waives his or her right to any hearing to which he or she might otherwise have been entitled. If the Provider waives his or her right to any hearing by failing to request a hearing within the time and in the manner specified above, the recommendation of the Peer Review Committee and/or Credentialing Committee taking or recommending the Adverse Action shall be forwarded to the Chief Medical Officer for final approval. In the event of a submittal to the Chief Medical Officer upon the Provider's waiver as set forth herein, the Peer Review Committee and/or Credentialing Committee may submit to the Chief Medical Officer additional information relevant to its recommended Adverse Action to be considered by the Chief Medical Officer in accepting or rejecting the recommended Adverse Action.

5. Appointment of a Hearing Committee

a) Composition of Hearing Committee - The Chief Medical Officer/Plan President shall select the individuals to serve on the Hearing Committee. The Hearing Committee shall consist of individuals who are not in direct economic competition with the subject Provider; who shall gain no direct financial benefit from the outcome of the hearing; and, who shall have not acted as accuser, investigator, fact finder, initial decision maker or otherwise have not actively participated in the consideration of the matter leading up to the recommendation or action. General knowledge of the matter involved shall not preclude a physician from serving as a member of the panel.

The panel shall consist of three or more Providers and shall include, whenever feasible, at least one individual practicing the same specialty as the affected Provider. In the event Providers are not available to sit as Hearing Committee members, physicians from the community may be substituted by the Medical Director.

b) Scope of Authority - The Hearing Committee shall have the authority to interpret and apply this Policy insofar as it relates to its powers and duties.

c) Responsibilities - The Hearing Committee shall:

- i. Evaluate evidence and testimony presented.
- ii. Issue a decision accepting, rejecting, or modifying the decision of the Peer Review Committee and/or Credentialing Committee.
- iii. Maintain the privacy of the hearing unless the law provides to the contrary.

- d) Vacancies – In the event of a vacancy in a hearing panel after a hearing has commenced, the remaining panel members may continue with the hearing and determination of the controversy, unless the parties agree otherwise.
- e) Disclosure and Challenge Procedures – Any person appointed to the Hearing Committee shall disclose to the Chief Medical Office/Plan President any circumstance likely to affect impartiality, including any bias or a financial or personal interest in the result of the hearing or any past or present relationship with the parties or their representatives. The Hearing Officer may remove any person appointed to the Hearing Committee if the Hearing Office believes that the person is unable to render an impartial decision.

6. Hearing Officer

- a) Selection - The Chief Medical Officer and/or Plan President shall appoint a Hearing Officer, who may be an attorney. The Hearing Officer shall gain no direct financial benefit from the outcome of the hearing, shall not act as a prosecuting officer or advocate, and shall not be entitled to vote.
- b) Scope of Authority - The Hearing Officer shall have the sole discretion and authority to:
 - i. Exclude any witness, other than a party or other essential person.
 - ii. Determine the attendance of any person other than the parties and their counsel and representatives.
 - iii. For good cause shown to postpone any hearing upon the request of a party or upon a Hearing Committee's own initiative and shall also grant such postponement when all of the parties agree thereto.
- c) Responsibilities - The Hearing Officer shall:
 - i. Guide the hearing process, including endeavoring to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner;
 - ii. Ensure that proper decorum is maintained;
 - iii. Be entitled to determine the order of, or procedure for, presenting evidence and argument during the hearing;
 - iv. Issue rulings pertaining to matters of law, procedure and the admissibility of evidence;
 - v. Issue rulings on any objections or evidentiary matters;
 - vi. Discretion to limit the amount of time;
 - vii. Assure that each witness is sworn in by the court reporter;
 - viii. May ask questions of the witnesses (but must remain neutral/impartial);
 - ix. May meet in private with the panel members to discuss the conduct of the hearing;
 - x. Remind all witnesses at the conclusion of their testimony of the confidentiality of the hearing;

- xi. Participate in the deliberations of the Hearing Committee as a legal advisor, but shall not be entitled to vote; and
- xii. Prepare the written report.

7. Time and Place of Hearing

Upon receipt of a Request for Hearing, the Chief Medical Officer and/or Plan President shall schedule and arrange for a hearing. The Chief Medical Officer and/or Plan President shall give notice to the affected Provider of the time, place and date of the hearing, as set forth below. The date of commencement of the hearing shall be not less than thirty (30) days from the date of the Notice of the Hearing, and not more than sixty (60) days from the date of receipt of the Request for Hearing. Notwithstanding the above timeframes, the parties may agree to extensions, or the Hearing Officer may grant an extension on a showing of good cause. If more than one meeting is required for a hearing, the Hearing Officer shall set the date, time, and location for additional meetings.

8. Notice of Hearing

The Notice of Hearing shall contain and provide the affected Provider with the following:

- a) The date, time and location of the hearing.
- b) The name of the Hearing Officer.
- c) The names of the Hearing Committee Members.
- d) A concise statement of the affected Provider's alleged acts or omissions giving rise to the Adverse Action or recommendation, and any other reasons or subject matter forming the basis for the Adverse Action or recommendation which is the subject of the hearing.
- e) The names of witnesses, so far as they are then reasonably known or anticipated, who are expected to testify on behalf of the Peer Review Committee and/or Credentialing Committee, provided the list may be updated as necessary and appropriate, but not later than ten (10) days prior to the commencement of the hearing.
- f) A list of all documentary evidence forming the bases of the charges reasonably necessary to enable the Provider to prepare a defense, including all documentary evidence which was considered by the Peer Review Committee and/or Credentialing Committee in recommending the Adverse Action.

Except with regard to the disclosure of witnesses, as set forth above, the Notice of Hearing may be amended from time to time, but not later than the close of the case at the conclusion of the hearing by the Hearing Committee. Such amendments may delete, modify, clarify or add to the acts, omissions, or reasons specified in the original Notice of Hearing.

9. Pre-Hearing Procedures

a) The Provider shall have the following pre-hearing rights:

- i. To inspect and copy, at the Provider's expense, documents upon which the charges are based which the Peer Review Committee and/or Credentialing Committee have in its possession or under its control; and
- ii. To receive, at least thirty (30) days prior to the hearing, a copy of the evidence forming the basis of the charges which is reasonably necessary to enable the Provider to prepare a defense, including all evidence that was considered by the Peer Review Committee and/or Credentialing Committee in recommending Adverse Action.

b) The Hearing Committee shall have the following pre-hearing right:

To inspect and copy, at Molina's expense, any documents or other evidence relevant to the charges which the Provider has in his or her possession or control as soon as practicable after receiving the hearing request.

c) The Hearing Officer shall consider and rule upon any request for access to information and may impose any safeguards required to protect the peer review process, privileges and ensure justice. In so doing, the Hearing Officer shall consider:

- i. Whether the information sought may be introduced to support or defend the charges;
- ii. The exculpatory or inculpatory nature of the information sought, if any;
- iii. The burden attendant upon the party in possession of the information sought if access is granted; and
- iv. Any previous requests for access to information submitted or resisted by the parties.

d) The Provider shall be entitled to a reasonable opportunity to question and object to or challenge the impartiality of members of the Hearing Committee and the Hearing Officer. Challenges to the impartiality of any Hearing Committee member or the Hearing Officer shall be ruled on by the Hearing Officer.

e) It shall be the duty of the Provider, the Peer Review Committee and/or Credentialing Committee to exercise reasonable diligence in notifying the Hearing Officer of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be succinctly made at the hearing.

f) Failure to disclose the identity of a witness or produce copies of all documents expected to be produced at least ten (10) days before the commencement of the hearing shall constitute good cause for a continuance or limitation of the evidence or the testimony if deemed appropriate by the Hearing Officer.

- g) The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable physicians or patients, other than the Provider under review, or to information, interviews, reports, statements, findings and conclusions resulting from studies or other data prepared specifically to be submitted for review purposes made privileged by operation of State.

10. Conduct of Hearing

- a) Rights of the Parties - Within reasonable limitations, and as long as these rights are exercised in an efficient and expeditious manner, both sides at the hearing may:
 - i. Call and examine witnesses for relevant testimony.
 - ii. Introduce relevant exhibits or other documents.
 - iii. Cross-examine or impeach witnesses who have testified orally on any matter relevant to the issues.
 - iv. Otherwise rebut evidence.
 - v. Have a record made of the proceedings.
 - vi. Submit a written statement at the close of the hearing.
 - vii. Receive the written recommendation of the Hearing Officer or Hearing Committee, including a statement of the basis for the recommendations, upon completion of the hearing.

The Provider may be called by the Peer Review Committee and/or Credentialing Committee and examined as if under cross-examination.

- b) Course of the Hearing
 - i. Each party may make an oral opening statement.
 - ii. The Peer Review Committee and/or Credentialing Committee shall call any witnesses and present relevant documentary evidence to support its recommendation.
 - iii. The affected Provider may then call any witnesses and present relevant documentary evidence supporting his/her defense.
 - iv. The Hearing Committee or Officer has the discretion to vary the course of the hearing, but shall afford a full and equal opportunity to all parties for the presentation of material and relevant evidence and for the calling of witnesses.
 - v. The Hearing Committee shall be the judge of the relevance and materiality of the evidence offered, and conformity to legal rules of evidence shall not be necessary. All evidence shall be taken in the presence of the entire Hearing Committee and all of the parties, except when agreed to by the parties, or determined by the Hearing Officer.
- c) Use of Exhibits
 - i. Exhibits, when offered by either party, may be received into evidence by the Hearing Committee as ruled upon by the Hearing Officer.

- ii. A description of the exhibits in the order received shall be made a part of the record.

d) Witnesses

- i. Witnesses for each party shall submit to questions or other examination.
- ii. The Hearing Officer shall have the power to sequester witnesses (exclude any witness, other than a party or other essential person, during the testimony of any other witness). The names and addresses of all witnesses and a description of their testimony in the order received shall be made a part of the record.
- iii. The Hearing Committee may receive and consider the evidence of witnesses by affidavit, but shall give it only such weight as the Hearing Committee deems it is entitled to after consideration of any objection made to its admission.
- iv. The party producing such witnesses shall pay the expenses of their witnesses.

e) Rules for Hearing:

- i. Attendance at Hearings
- ii. Only those persons having a direct interest in the hearing are entitled to attend the hearing. This means that the hearing will be closed except for the parties and their representatives. The only exception is when good cause is shown satisfactory to the Hearing Officer that it is necessary in the interest and fairness of the hearing to have others present.
- iii. Communication with Hearing Committee
- iv. There shall be no direct communication between the parties and the Hearing Committee other than at the hearing, unless the parties and the Hearing Committee agree otherwise. Any other oral or written communication from the parties to the Hearing Committee shall be directed to the Hearing Officer for transmittal to the Hearing Committee.
- v. Interpreter
- vi. Any party wishing to utilize an interpreter shall make all arrangements directly with the interpreter and shall assume the costs of the services.

11. Close of the Hearing

At the conclusion of the hearing, the Hearing Officer shall dismiss all parties and participate in the deliberations of the Hearing Committee. The Hearing Committee shall render its final decision by a majority vote, including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached to the Hearing Officer.

Within thirty (30) days of the conclusion of the deliberations, the Hearing Officer shall issue a written report including the following:

- a) A summary of facts and circumstances giving rise to the hearing.
- b) A description of the hearing, including:
 - i. The panel members' names and specialties;
 - ii. The Hearing officer's name;
 - iii. The date of the hearing;
 - iv. The charges at issue; and
 - v. An overview of witnesses heard and evidence.
- c) The findings and recommendations of the Hearing Committee.
- d) Any dissenting opinions desired to be expressed by the hearing panel members.

Final adjournment of the Hearing Committee shall occur when the Hearing Officer has mailed or otherwise delivered the written report.

12. Burden of Proof

In all hearings it shall be incumbent on the Peer Review Committee and/or Credentialing Committee taking or recommending an Adverse Action to come forward initially with evidence in support of its action or decision. Thereafter, the Provider who requested the hearing shall come forward with evidence in his/her support.

The burden of proof during a hearing shall be as follows:

The Peer Review Committee or Credentialing Committee taking or recommending the Adverse Action shall bear the burden of persuading the Hearing Committee that its action or recommendation is reasonable and warranted. The term "reasonable and warranted" means within the range of alternatives reasonably available to the Peer Review Committee and/or Credentialing Committee taking or recommending Adverse Action under the circumstances and not necessarily that the action or recommendation is the only measure or the best measure that could have been taken or formulated.

13. Provider Failure to Appear or Proceed

Failure, without good cause, of the Provider to personally attend and proceed at a hearing in an efficient and orderly manner shall be deemed to constitute voluntary acceptance of the recommendations or actions involved.

14. Record of the Hearing/Oath

A court reporter shall be present to make a record of the hearing proceedings and the pre-hearing proceedings, if deemed appropriate by the Hearing Officer. The cost of attendance of the reporter shall be borne by Molina, but the cost of the transcript, if any, shall be borne by the party requesting it. The Hearing Officer shall be required to order that all oral evidence be taken by oath administered by a person lawfully authorized to administer such oath.

15. Representation

Each party shall be entitled to representation by an attorney at law, or other representative at the hearing, at their own expense, to represent their interests, present their case, offer materials in support thereof, examine witnesses, and/or respond to appropriate questions.

16. Postponements

The Hearing Officer, for good cause shown, may postpone any hearing upon the request of a party or the Hearing Committee.

17. Notification of Finding

The Hearing Office shall serve a copy of the written report outlining the basis of the Hearing Committee's decision to the Medical Director, the Peer Review Committee and/or Credentialing Committee imposing the Adverse Action, and the affected Provider.

18. Final Decision

Upon receipt of the Hearing Committee's decision, the Chief Medical Officer/Plan President shall either adopt or reject the Hearing Committee's decision. The Chief Medical Officer/Plan President's action constitutes the final decision.

19. Reporting

In the event the Chief Medical Officer/Plan President adopts the proposed decision of the Peer Review Committee and/or Credentialing Committee taking or recommending the Adverse Action, Molina will submit a report to the State Licensing Board, NPDB, and/or HIPDB, as required. Reports shall be made in accordance with the Credentialing Program Policy.

20. Exhaustion of Internal Remedies

If any of the above Adverse Actions are taken or recommended, the Provider must exhaust the remedies afforded by this Policy before resorting to legal action.

XIV. Member Grievances and Appeals

Molina Medicare Members have the right to file and submit a grievance and/or appeal through a formal process. Members may elect a personal representative or a provider to file the grievance or appeal on their behalf.

A. Complaints, Grievances and Appeals Process

- 1. Complaints** – may be either grievances or appeals or both and may be processed under one or both procedures. The Appeals and Grievance Form can be completed by the member or representative when filing and submitting a grievance or appeal.

Each issue is adjudicated separately. **Complaints or disputes involving organization determinations are processed as appeals.** All other issues are processed as grievances. General guidelines that are used to determine the category of the complaint are:

- The grievance process will be used for complaints concerning disenrollment, cost sharing, changes in premiums, and access to a provider or Molina Medicare;
- Changes in provider availability to a specific member will be considered an organization determination; and/or
- The QIO process is used for complaints regarding quality of medical care.

- 2. Grievances** – Grievance procedures are as follows:

- Molina Medicare will accept any information or evidence concerning the grievance orally or in writing not later than sixty (60) days after the event and will thoroughly investigate, track and process the grievance within thirty (30) days unless an extension is granted;
- If Molina Medicare extends the time necessary or refuses to grant an organization determination or reconsideration Molina Medicare will respond to the member within twenty-four (24) hours; and
- Complaints concerning the timely receipt of services already provided are considered grievances.

Quality of Care – Molina members have a right file a complaint regarding the care provided. Molina must respond to all Quality of Care complaints in writing to the member. Molina Medicare monitors, manages, and improves the quality of clinical care and services received by its members by investigating all issues including Serious Adverse Events, Hospital Acquired Conditions and Never Events. Members may also file care complaints with the State’s contracted and CMS assigned Quality Improvement Organization.

- 3. Organization Determination**

Organization Determinations are any determinations (an approval, modification or denial) made by Molina Medicare regarding payment or services to which a member believes he/she is entitled such as temporarily out-of-area renal dialysis services, emergency services, post-stabilization care, or urgently needed services.

Molina Medicare’s Utilization Management Department handles organization determination. Organization Determination is discussed in Chapter XV. Any party to an organizational determination, e.g., a member, a member’s representative or a non-contracted provider, or a termination of services decision, may request that the determination be reconsidered.

Organization determinations are either standard or expedited depending on the urgency of the member’s request.

4. Part-D Appeals – Please see Section XV – Medicare Part D, Section A

B. Definition of Key Terms used in the Molina Medicare Grievance and Appeal Process

The definitions that follow will clarify terms used by Molina Medicare for member Medicare appeals and grievances. Following the definitions is a brief discussion of Molina Medicare grievance and appeal processes. Any questions on these polices should be directed to your Provider Services Representative.

Appeal	Any of the procedures that deal with the review of adverse organization determinations on the healthcare services a member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the healthcare services (such that a delay would adversely affect the health of the member), or on any amounts the member must pay for a service as defined in 42 CFR 422.566(b). These procedures include reconsideration by Molina Medicare and if necessary, an independent review entity, hearing before an Administrative Law Judge (ALJ), review by the Medicare Appeals Council (MAC), and judicial review.
Assignee	A non-contracted provider who has furnished a service to the member and formally agrees to waive any right to payment from the member for that service.
Complaint	Any expression of dissatisfaction to Molina Medicare, provider, facility or Quality Improvement Organization (QIO) by a member made orally or in writing. This can include concerns about the operations of providers or Molina Medicare such as: waiting times, the demeanor of healthcare personnel, the adequacy of facilities, the respect paid to Members, the claims regarding the right of the member to receive services or receive payment for services previously rendered. It also includes a plan’s refusal to provide services to which the member believes he or she is entitled. A complaint could be either a grievance or an appeal, or a single complaint could include elements of both. Every complaint must be handled under the appropriate grievance and/or appeal process.
Coverage Determination: Denial Notices	A written denial notice by a Molina Medicare that states the specific reasons for the denial and informs the member of his or her right to reconsideration. The notice describes both the standard and expedited appeals processes and the rest of the appeals process. For payment denials, the notice describes the standard redetermination process and the rest of the appeals process.
Effectuation	Compliance with a reversal of Molina Medicare’s original adverse

	organization determination. Compliance may entail payment of a claim, authorization for a service, or provision of services.
Member	A Medicare-eligible individual who has elected a Medicare plan offered by a Medicare Advantage organization, or a Medicare eligible individual who has elected a cost plan or HCPP.
Independent Review Entity	An independent entity contracted by CMS to review Molina Medicare's adverse reconsiderations of organization determinations.
Inquiry	Any oral or written request to Molina Medicare, provider, or facility, without an expression of dissatisfaction, e.g., a request for information or action by a member.
Medicare Plan	A plan defined in 42 CFR. 422.2 and described at 422.4.
Organization Determination	Any determination made by Molina Medicare with respect to any of the following: <ul style="list-style-type: none"> ▪ Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services; ▪ Payment for any other health services furnished by a provider other than a Molina Medicare Provider that the member believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for, or reimbursed by Molina Medicare; ▪ Molina Medicare's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the member believes should be furnished or arranged for by the Medicare health plan; ▪ Discontinuation of a service if the member believes that continuation of the services is medically necessary; and/or ▪ Failure of Molina Medicare to approve, furnish, arrange for, or provide payment for healthcare services in a timely manner, or to provide the member with timely notice of an adverse determination, such that a delay would adversely affect the health of the member.
Quality Improvement Organization (QIO)	Organizations comprised of practicing doctors and other healthcare experts under contract to the Federal government to monitor and improve the care given to Medicare Members. QIOs review complaints raised by Members about the quality of care provided by providers, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Molina Medicare, and ambulatory surgical centers. The QIOs also review continued stay denials for Members receiving care in acute inpatient hospital facilities as well as coverage terminations in SNFs, HHAs and CORFs.
Quality of Care Issue	A quality of care complaint may be filed through the Molina Medicare's grievance process and/or a QIO. A QIO must determine whether the quality of services (including both inpatient and outpatient services) provided by Molina Medicare meets professionally recognized standards of healthcare, including whether appropriate healthcare services have been provided and whether services have been provided in appropriate settings.
Reconsideration	A member's first step in the appeal process after an adverse organization determination; Molina Medicare or independent review entity may reevaluate an adverse organization determination, the findings upon which it was based, and any other evidence submitted or obtained.
Representative	An individual appointed by a member or other party, or authorized under

	State or other applicable law, to act on behalf of a member or other party involved in the appeal. Unless otherwise stated, the representative will have all of the rights and responsibilities of a member or party in obtaining an organization determination or in dealing with any of the levels of the appeals process, subject to the applicable rules described in 42 CFR part 405.
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C. Important Information about Member Appeal Rights

For information about members’ appeal rights, call the **Molina Medicare Member Service Department Monday through Sunday 8:00 a.m. to 8:00 p.m. toll free at (866) 472-4584 or 711 for persons with hearing impairments (TTY/TDD).**

Below is information for Molina Members regarding their appeal rights. A detailed explanation of the appeal process is included in the member’s Evidence of Coverage (EOC) that has been provided to them. If Members have additional questions, please refer them to Molina Medicare Member Services.

<p>There Are Two (2) Kinds of Appeals You Can File:</p> <p>Standard Appeal Thirty (30) days – You can ask for a standard appeal. Your plan must give you a decision no later than thirty (30) days after it gets your appeal. Your plan may extend this time by up to fourteen (14) days if you request an extension, or if it needs additional information and the extension benefits you.</p> <p>Fast Seventy-two (72) hour review – You can ask for a fast appeal if you or your doctor believe that your health could be seriously harmed by waiting too long for a decision. Your plan must decide on a fast appeal no later than seventy-two (72) hours after it gets your appeal. Your plan may extend this time by up to fourteen (14) days if you request an extension, or if it needs additional information and the extension benefits you.</p> <p>If any provider asks for a fast appeal for you, or supports you in asking for one, and the provider indicates that waiting for thirty (30) days could seriously harm your health, your plan will automatically give you a fast appeal.</p> <p>If you ask for a fast appeal without support from your provider, your plan will decide if your health requires a fast appeal. If your plan does</p>	<p>What do I include with my Appeal? You should include your name, address, member ID number, reason for appealing and any evidence you wish to attach. You may send in supporting medical records, provider’s letter(s), or other information that explains why your plan should provide service. Call your provider if you need this information to help with your appeals.</p> <p>How do I file an Appeal? For Standard Appeal: you or your authorized representative should mail or deliver your written appeal to Molina Medicare at:</p> <p>Molina Medicare</p> <p>Attn: Grievance and Appeals P.O. Box 22816 Long Beach, CA 90801-9977</p> <p>Hours of Operation: Monday through Sunday 8:00 a.m. to 8:00 p.m.</p> <p>To file an oral grievance call us toll free: (866) 472-4584 TTY/TDD toll free access number: 711 Fax Number (not toll free): (562) 499-0610 Other resources:</p>
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not give you a fast appeal, your plan will decide your appeal in thirty (30) days

Medicare Rights Center:

Toll free: (888) HMO-9050

Toll free: (800) MEDICARE -(800)-633-4227)

If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, **you can call the Office for Civil Rights toll free at (800) 368-1019 or TTY/TDD (800) 537-7697, or call your local Office for Civil Rights.**

XV. Medicare Part D

A Part D coverage determination is a decision about whether to provide or pay for a Part D drug. A decision concerning a tiering exception request, a formulary exception request a decision on the amount of cost sharing for a drug or whether a member has or has not satisfied a prior authorization or other UM requirement.

Any party to a coverage determination, (e.g., a member, a member's representative) may request that the determination be appealed. A member, a member's representative, or provider, are the only parties who may request that Molina Medicare expedite a coverage determination or redetermination. The member's provider is prohibited from requesting a standard redetermination or higher appeal without being the member's appointed representative.

Coverage determinations are either standard or expedited depending on the urgency of the member's request.

A. Appeals/Redeterminations

When a member's request for a coverage determination is denied, members may choose someone (including an attorney or provider) to serve as their personal representative to act on their behalf. After the date of the denial, a member has up to sixty (60) days to request a redetermination. This is the first level of appeal for Part D adverse decisions. Appeal data is confidential.

The redetermination request will be responded to within seven (7) days. If an expedited appeal is required for an emergent situation, then the decision will be made within seventy-two (72) hours of the request.

At any time during the appeal process, the member or personal representative may submit written comments, papers or other data about the appeal in person or in writing. If the appeal/reconsideration is denied, the member has the right to send the appeal to the Independent Review Entity (IRE) within sixty (60) days of receipt of the appeal. The IRE has seven (7) days to make a decision for a standard appeal/reconsideration and seventy-two (72) hours for an expedited request. The IRE will notify Molina Medicare and the member of the decision. When an expedited review is requested, the IRE will make a decision within seventy-two (72) hours.

If the IRE changes the Molina Medicare decision, authorization for service must be made within seventy-two (72) hours for standard appeals and within twenty-four (24) hours for expedited appeals.

Payment appeals must be paid within thirty (30) days from the date the plan receives notice of the reversal.

If the IRE upholds Molina Medicare's denial they will inform the member of their right to a hearing with the ALJ and will describe the procedures that must be followed to obtain an ALJ hearing.

CMS's IRE monitors Molina Medicare's compliance with determinations to decisions that fully or partially reverse an original Molina Medicare denial. The IRE is currently Maximums Federal Services, Inc.

B. Part D Prescription Drug Exception Policy

CMS defines a coverage determination as the first decision made by a plan regarding the prescription drug benefits a member is entitled to receive under the plan, including a decision not to provide or pay for a Part D drug, a decision concerning an exception request, and a decision on the amount of cost sharing for a drug.

An exception request is a type of coverage determination request. Through the exceptions process, a member can request an off-formulary drug, an exception to the plan's tiered cost sharing structure, and an exception to the application of a cost UM tool (e.g., step therapy requirement, dose restriction, or prior authorization requirement).

Molina Medicare is committed to providing access to medically necessary prescription drugs to Members of Molina Medicare. If a drug is prescribed that is not on Molina Medicare's formulary, the member or member's representative may file for an exception. All exceptions and appeals are handled at the plan level (on-site) and are not delegated to another entity. Please see below for contact information by plan for personnel who handle the exceptions. Members or the member's representatives (who can include providers and pharmacists) may call, write, fax, or e-mail Molina Medicare's exception contact person to request an exception. Procedures and forms to apply for an exception may be obtained from the contact persons.

Part D Exceptions and Appeals Contact Information: call **toll free Molina Medicare at (866)-472-4584 or fax (866) 450-3914.**

The Policy and Procedure for Exceptions and Appeals will be reviewed by a Pharmacy and Therapeutics (P&T) Committee on an annual basis at minimum. Exception / Prior Authorization criteria are also reviewed and approved by a P&T Committee.

- 1. Formulary** - A formulary is a list of medications selected by Molina Medicare in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. Molina Medicare will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Molina Medicare network pharmacy and other plan rules are followed.

Formularies may be different depending on the Molina Medicare Plan and will change over time. Current formularies for all products may be downloaded from our Website at www.MolinaMedicare.com.

2. Copayments for Part D - The amount a patient pays depends on which drug tier the drug is in under the plan and whether the patient fills the prescription at a preferred network pharmacy.

- Most Part D services have a co-payment;
- Co-payments cannot be waived by Molina Medicare per the Centers for Medicare & Medicaid Services; and
- Co-payments for Molina Medicare may differ by state and plan.

2013 Drug Tier for Molina Medicare of Ohio	2013 Options Plus (HMO SNP) Special Needs Plan*
Formulary Generic – Tier One	[\$0 or \$1.15 or \$2.65] [\$0 for TX and FL]
Formulary Preferred Brand – Tier Two	\$0 or \$3.50 copay or \$6.60 copay
Formulary Non-Preferred Brand – Tier Three	\$0 or \$3.50 copay or \$6.60 copay
Specialty Drugs – Tier Four	\$0 or \$3.50 copay or \$6.60 copay

***Please note: At CMS’s discretion, co-payments and/or benefit design may change at the beginning of the next contract year and each year thereafter.**

3. Restrictions on Molina Medicare Drug Coverage

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization:** Molina Medicare requires prior authorization for certain drugs, some of which are on the formulary and also drugs that are not on the formulary. Without prior approval, Molina Medicare may not cover the drug;
- **Quantity Limits:** For certain drugs, Molina Medicare limits the amount of the drug that it will cover;
- **Step Therapy:** In some cases, Molina Medicare requires patients to first try certain drugs to treat a medical condition before it will cover another drug for that condition. For example, if Drug A and Drug B both treat a medical condition, Molina Medicare may not cover drug B unless drug A is tried first; and/or
- **Part B Medications:** Certain medications and/or dosage forms listed in this formulary may be available on Medicare Part B coverage depending upon the place of service and method of administration.

4. Non-Covered Molina Medicare Part D Drugs:

- Agents when used for anorexia, weight loss, or weight gain (no mention of medically necessary);
- Agents when used to promote fertility;
- Agents used for cosmetic purposes or hair growth;
- Agents used for symptomatic relief of cough or colds;
- Prescription vitamins and minerals, except those used for prenatal care and fluoride preparations;
- Non-prescription drugs, except those medications listed as part of Molina Medicare's over-the-counter (OTC) monthly benefit as applicable and depending on the plan;
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee as a condition of sale;
- Molina Medicare Members with Medicaid coverage may have a limited selection of these excluded medications as part of its Medicaid coverage for Members assigned to Molina Medicaid.

5. There may be differences between the Medicare and Medicaid Formularies. The Molina Medicare Formulary includes many injectable drugs not typically found in its Medicaid formularies such as those for the aged, blind and disabled.

6. Requesting a Molina Medicare Formulary Exception - Molina Medicare product drug prior authorizations are called Exceptions, which are required when your patient needs a drug that is not on the Formulary. A member, a member's appointed representative or a member's prescribing provider are permitted to file an Exception. (The process for filing an exception is predominantly a fax based system.) The form for exception requests is available on the Molina Medicare website www.MolinaMedicare.com.

7. Requesting a Molina Medicare Formulary Redetermination (Appeal) - The appeal process involves an adverse determination regarding Molina Medicare issuing a denial for a requested drug or claim payment. If the member received a Notice of Denial of Medicare Prescription Drug Coverage and disagrees with the decision rendered, he/she may request a redetermination (appeal) from Molina Medicare by completing the appeal form sent with the Notice of Denial.

A member, a member's appointed representative or a member's prescribing provider (for expedited appeals) may complete the appeal form and submit any information which may help Molina Medicare with the processing of the appeal. An appeal must be submitted in writing and filed within sixty (60) calendar days from the date that the determination was rendered.

- A standard appeal may be submitted to Molina Medicare in writing or can be taken over the telephone. The appeal will be reviewed upon receipt and the member will be

notified in writing within seven (7) calendar days from the date the request for re-determination is received.

- An expedited appeal can be requested orally or in writing by the member or by a provider acting on behalf of the member. An expedited appeal may be requested in situations where applying the standard time frame could seriously jeopardize the member's life, health or ability to regain maximum function. If a provider supports the request for an expedited appeal, Molina Medicare will honor this request.
- If a member submits an appeal without provider support, Molina Medicare will review the request to determine if it meets Medicare's criteria for expedited processing. If the plan determines that the request meets the expedited criteria, Molina Medicare will render a decision as expeditiously as the member's health requires, but not exceeding seventy-two (72) hours. If the request does not meet the expedited criteria, Molina Medicare will render a coverage decision within the standard redetermination time frame of seven (7) calendar days.
- To submit a verbal request, please call **toll free (866) 472-4584**. Written appeals must be mailed or **faxed toll free (866) 450-3914**.

8. Initiating a Part D Exception (Prior Authorization) Request - Molina Medicare will accept requests from providers or a pharmacy on the behalf of the member either by a written or verbal request. The request may be communicated through the standardized Molina Medicare Medication Prior Authorization Request Form or through telephone via fax and telephone lines. All requests will be determined and communicated to the member and the member's prescribing provider with an approval or denial decision within seventy-two (72) hours / three (3) calendar days after Molina Medicare receives the completed request.

Molina Medicare will request submission of additional information if a request is deemed incomplete for a determination decision. All requests may be approved by: 1) Molina Medicare Pharmacy Technician under the supervision of a pharmacist; 2) Molina Medicare Pharmacist; or, 3) Chief Medical Officer (CMO) of Molina Medicare. Review criteria will be made available at the request of the member or his/her prescribing provider. Molina Medicare will determine whether a specific off-label use is a medically accepted indication based on the following criteria:

- a. A prescription drug is a Part D drug only if it is for a medically accepted indication, which is supported by one or more citations included or approved for inclusion with the following compendia:
 - American Hospital Formulary Service Drug Information;
 - United States Pharmacopeia-Drug Information (or its successor publications); and
 - DRUGDEX Information System.
- b. Requests for off-label use of medications will need to be accompanied with excerpts from one (1) of the seven (7) CMS-required compendia for consideration. The submitted excerpts must site a favorable recommendation.

- c. Depending upon the prescribed medication, Molina Medicare may request the prescribing provider to document and justify off-label use in clinical records and provide information such as diagnostic reports, chart notes, and medical summaries.

Denial decisions are only given to the member or member's representative by a Pharmacist or CMO of Molina Medicare. The written denial notice to the member (and the prescriber involved) includes the specific rationale for denial; the explanation of both the standard and expedited appeals process; and an explanation of a member's right to, and conditions for, obtaining an expedited an appeals process.

If Molina Medicare denies coverage of the prescribed medication, Molina Medicare will give the member a written notice within seventy-two (72) hours explaining the reason for the denial and how to initiate the appeals process. If no written notice is given to the member within the specified timeframe, Molina Medicare will start the next level of appeal by sending the Coverage Determination request to the Independent Review Entity (IRE) within twenty-four (24) hours.

If a coverage determination is expedited, Molina Medicare will notify the member of the coverage determination decision within the twenty-four (24) hour timeframe by telephone and mail the member a written Expedited Coverage Determination within three (3) calendar days of the oral notification. If Molina Medicare does not give the member a written notification within the specified timeframe, Molina Medicare will start the next level of appeal by sending the Coverage Determination request to the Independent Review Entity (IRE) within twenty-four (24) hours.

- 9. Initiating a Part D Appeal** - If Molina Medicare's initial coverage determination is unfavorable, a member may request a first level of appeal, or re-determination within sixty (60) calendar days from the date of the notice of the coverage determination. In a Standard Appeal Molina Medicare has up to seven (7) days to make the re-determination, whether favorable or adverse, and notify the member in writing within seven (7) calendar days from the date the request for re-determination is received. Members or a member's prescribing provider may request Molina Medicare to expedite a redetermination if the standard appeal timeframe of seven (7) days may seriously jeopardize the member's life, health, or ability to regain maximum function. Molina Medicare has up to seventy-two (72) hours to make the re-determination, whether favorable or adverse, and notify the member in writing within seventy-two (72) hours after receiving the request for re-determination. If additional information is needed for Molina Medicare to make a re-determination, Molina Medicare will request the necessary information within twenty-four (24) hours of the initial request for an expedited re-determination. Molina Medicare will inform the member and prescribing provider of the conditions for submitting the evidence since the timeframe is limited on expedited cases.
- 10. The Part D Independent Review Entity (IRE)** - If the re-determination is unfavorable, a member may request reconsideration by the IRE. The Part D Qualified Independent Contractor (IRE) is currently MAXIMUS Federal, a CMS contractor that provides second level appeals.

- **Standard Appeal:** The IRE has up to seven (7) days to make the decision.
- **Expedited Appeal:** The IRE has up to seventy-two (72) hours for to make the decision.
- **Administrative Law Judge (ALJ):** If the IRE's reconsideration is unfavorable, a member may request a hearing with an ALJ if the amount in controversy requirement is satisfied.
- **Note:** Regulatory timeframe is not applicable on this level of appeal.
- **Medicare Appeals Council (MAC):** If the ALJ's finding is unfavorable, the member may appeal to the MAC, an entity within the Department of Health and Human Services that reviews ALJ's decisions. Note: Regulatory timeframe is not applicable on this level of appeal.

11. Federal District Court (FDC) - If the MAC's decision is unfavorable, the member may appeal to a Federal district court, if the amount in controversy requirement is satisfied. Note: Regulatory timeframe is not applicable on this level of appeal.

XVI. Web-Portal

Molina Medicare Providers may register on the Web Portal to verify member eligibility and benefits, search for service request/authorizations and claims and view other information that is helpful.

- **Enhanced Security** – Online access is more secure than phone or fax so providers are encouraged to communicate with Molina Medicare online. A new provider registration process that includes a how-to video guides providers on the E-Portal registration process. Providers may add additional users to their accounts. The level of access to information can be better controlled online, further improving information security.
- **Claim Status Updates and Status Change Notifications** – The system provides real-time updates when viewing claims status information so providers will know sooner if a claim is paid or denied. Messaging capabilities will automatically notify providers of claims and service request/authorization status changes.
- **Service Request/Authorization Enhancements** – Providers are able to apply templates to requests that they use frequently, to copy information from previous requests, and to attach documentation and clinical notes, reducing the time it takes to prepare and submit requests. Providers are also able to view service requests/authorizations for their patients/Molina Medicare members and will receive notifications when they create a service request/authorization to determine if a patient/Molina Medicare member previously received the service.
- **Member Eligibility** – Access to member eligibility details – with a Quick View bar that summarizes the member’s eligibility at a glance. Additional member details include member HEDIS missed services, benefit summary of covered services and access to member handbooks.

XVII. Risk Adjustment Management Program

A. Background

Risk Adjustment is a payment methodology designed to pay appropriate premiums for each Molina Medicare member. CMS bases its premium payment according to the health status of each member – more reimbursement for sicker, less healthy members and less reimbursement for healthy members. Member health status is determined according to diagnosis codes submitted by Molina Medicare to CMS from claims data/encounters and other valid sources, i.e. medical record audits.

The data submitted to CMS is predictive of future medical expenses; the data collected in the current year determines the premium for the following year. The premium amount would cover the cost of any episodic acute care as well as progression into chronic conditions. In order to ensure that the premium Molina Medicare receives actually covers the cost of care, it is necessary that Molina Medicare receives complete, accurate and comprehensive diagnostic data from providers and hospitals and that data is renewed for each reporting period.

The Molina Risk Adjustment Management Program (RAMP) helps to identify unreported or under reported conditions (known as “suspects”). RAMP utilizes systems, tools and vendor services to calculate the risk adjustment score, which is the accumulation of all the factors that go into calculating the premium payment amount. This score also allows an easy identification of members according to their health status. Sick = higher number. Healthy = lower number. The health plan will use the suspects to perform chart audits that should generate additional data to submit to CMS.

CMS takes the data submitted from Molina Medicare that has been approved and calculates the premium. The premium factors consist of values for age, sex, Medicaid eligibility (poverty), disability, and the Hierarchical Condition Categories (HCCs). The total score, or Risk Adjustment Factor, is then multiplied by the rate book or the bid amount to obtain the total premium amount paid to Molina Medicare.

- Every year there is an open enrollment period when beneficiaries may choose which health plan to join. Medicare plans compete by offering different benefit packages with different premiums.
- The Medicare plans submit bids to CMS each year, essentially saying that they can provide the enumerated benefits for a certain amount. When CMS accepts a bid, the plan is held to that premium amount. The amount they bid is directly dependent upon the revenue that they anticipate receiving from risk adjustment.
- Therefore, the accurate submission of data for risk adjustment is critical to the care of our Members.

B. Required Submissions

The Risk Adjustment Management Program at Molina is responsible for analyzing encounter data for Molina Members submitted by hospitals and other inpatient facilities, hospital

outpatient facilities, physician groups, IPAs and other providers contracted with Molina Medicare. This includes all subcontracted and sub-capitated providers to a capitated entity.

C. Data Submission Reporting

Molina currently contracts with Emdeon to capture encounter data. Emdeon accommodates claims data in either hard copy or electronic submission. The preferred media is electronic submission.

D. Diagnosis and Procedure codes

Each diagnosis code is validated against the ICD-9-CM codes that are in effect for the dates of service for the claim/encounter. ICD-9-CM must be coded to the highest level of specificity, this means using the required third, fourth or fifth digits as specified in ICD-9-CM.

Procedure codes and procedure modifiers are matched against the particular coding scheme used (CPT codes, HCPCS codes, UB92 Revenue codes or ICD-9-CM procedure codes). Codes are validated for the coding scheme in effect for the dates of service for the encounter.

Providers should use only the current ICD-9-CM, HCPCS and CPT codes effective for the date of service. If a diagnosis, procedure or procedure modifier code does not validate against the coding scheme, the encounter record is held at Emdeon (or contracted Clearinghouse) until the error is resolved.

It is the responsibility of the physician group or facility to correct any ICD9 code errors and re-submit the corrected encounters to your contracted clearinghouse. Once the error correction passes the clearinghouse's validation checks, the encounter record will be released to Molina Medicare.

Errors need to be corrected in a timely fashion. CMS sets deadlines based on date of service when accepting encounters. If an encounter is not corrected and re-submitted, it cannot be sent to CMS to be included in Risk Adjustment calculations. See Section F below: Risk Adjustment Submission Timetable.

E. Medicare Regulations

Molina Medicare requires that submissions be complete and timely in order to comply with CMS submission deadlines and current regulations. CMS requires related entities, contractors or subcontractors to Molina Medicare to certify the accuracy, completeness and truthfulness of encounter data. CMS has instituted a program of Risk Adjustment Data Validation (RADV) that includes both random and targeted medical record review of encounter data submitted to CMS.

F. Risk Adjustment Submission Timetable

Payment Year (PY)	Model Run	Date Data Due for Inclusion in Model Run	Dates of Service Included in Model Run	Payment Date Following Model Run
2012	Initial	9/2/2011	7/1/2010 - 6/30/2011	January 2012
2012	Mid-Year	3/2/2012	1/1/2011 - 12/31/2011	July 2012
2012	Final Reconciliation	1/31/2013	1/1/2011 - 12/31/2011	August 2013
2013	Initial	9/7/2012	7/1/2011 - 6/30/2012	January 2013
2013	Mid-Year	3/1/2013	1/1/2012 - 12/31/2012	July 2013
2013	Final Reconciliation	1/31/2014	1/1/2012 - 12/31/2012	August 2014
2014	Initial	9/6/2013	7/1/2012 - 6/30/2013	January 2014
2014	Mid-Year	3/7/2014	1/1/2013 - 12/31/2013	July 2014
2014	Final Reconciliation	1/31/2015	1/1/2013 - 12/31/2013	August 2015

G. Contact Information

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VIII. Glossary

Term	Definition
Appeal	A complaint lodged by a member if they disagree with certain kinds of decisions made by the health plan.
Abuse	Practices that are inconsistent with sound fiscal, business, or medical practices, that result in an unnecessary cost to the government program or in reimbursement for services that are not medically necessary, or fail to meet professionally recognized standards for healthcare.
Case Management	A collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to accommodate the specific health services needed by an individual.
Claim	A request for payment for the provision of Covered Services prepared on a CMS1500 form, UB92, or successor.
CMS	Centers for Medicare and Medicaid Services
Co-insurance	The amount a member pays for medical services after the deductible is paid. Coinsurance amounts are usually percentages of approved amounts.
Co-payment or Copay	The amount a member pays for medical services such as a provider's visit or prescription.
Deductible	The amount a member pays for healthcare or prescriptions, before the health plan begins to pay.
Disenroll	Ending healthcare coverage with a health plan.
Division of Financial Responsibility (DOFR)	A document whereby health plans assign the payment risk for any contract, dividing payment responsibilities among the plan itself, the contracted hospital, or a Medical Group/IPA.
Durable Medical Equipment (DME)	Purchased or rented items such as hospital beds, iron lungs, oxygen equipment, seat lift equipment, wheelchairs, and other medically necessary equipment prescribed by a healthcare provider to be used in a patient's home.
Eligibility List	A list of Members that are assigned to Primary Care Providers (PCP) through a Medical Group, IPA or Staff Model Organization.
Emergency Services/Care	Care given for a medical emergency when a member believes that his/her health is in serious danger when every second counts.
Encounter Data	Claims data for services rendered to Members who are assigned to a PCPs through a capitated Medical Group or IPA, or Staff Model Organization.
Enrollment	The process by which an eligible person becomes a member of a managed care plan.
EOB	Explanation of Benefits.
Experimental	Items and procedures determined by Medicare not to be generally accepted by the medical community.
Formulary	A list of certain prescription drugs that the health plan will cover subject to limits and conditions.

Term	Definition
Fraud	Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to oneself or some other person. This includes any act that constitutes fraud under applicable Federal or State law.
Grievance	A complaint about the way a Medicare health plan is giving care.
Health Maintenance Organization Plan	A type of Medicare Plan that is available in some areas of the country. Plans must cover all Medicare Part A and Part B health care. Some HMOs cover extra benefits, like extra days in the hospital. In most HMOs, you can only go to doctors, specialists, or hospitals on the plan's list except in an emergency. HMO costs may be lower than in the Original Medicare Plan.
Home Health Agency	An organization that gives home care services, like skilled nursing care, physical therapy, occupational therapy, speech therapy, and personal care by home health aides.
Hospice Services	Hospice is a special way of caring for people who are terminally ill, and for their family. This care includes physical care and counseling.
Institution	A facility that meets Medicare's definition of a long-term care facility, such as a nursing home or skilled nursing facility. Assisted or adult living facilities, or residential homes, are not included.
IPA (Independent Practice Association)	An IPA is an association of providers and other healthcare providers, including hospitals, who contract with HMOs to provide services to the HMO Members, but usually also see non-HMO patients.
Long-Term Care	A variety of services that help people with health or personal needs and activities of daily living over a period of time. Long-term care can be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities. Most long-term care is custodial care. Medicare does not pay for this type of care if this is the only care needed.
Managed Care	A variety of services that help people with health or personal needs and activities of daily living over a period of time. Long-term care can be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities. Most long-term care is custodial care. Medicare does not pay for this type of care if this is the only care needed.
Medicaid	A joint Federal and State program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most healthcare costs are covered if a member qualifies for both Medicare and Medicaid.
Medically Necessary	Services or supplies that are proper and needed for the diagnosis or treatment of a medical condition, meet the standards of good medical practice in the local area, and aren't mainly for the convenience of the member or the doctor.
Medicare (Original Medicare)	A pay-per-visit health plan that lets Members go to any provider, hospital, or other healthcare supplier who accepts Medicare and is accepting new Medicare patients. Members must pay the deductible.

Term	Definition
	Medicare pays its share of the Medicare approved amount, and Members pay a share (co-insurance). In some cases Members may be charged more than the Medicare-approved amount. The Original Medicare Plan has two (2) parts: Part A (Hospital Insurance) and Part B (Medical Insurance).
Medicare Plan	A plan offered by a private company that contracts with Medicare to provide Members with all Medicare Part A and Part B benefits. In most cases, Medicare Plans also offer Medicare prescription drug coverage.
Member	A Medicare-eligible individual who is eligible and enrolled in a Molina Medicare health plan.
Network	A group of doctors, hospitals, pharmacies, and other healthcare experts hired by a health plan to take care of its Members.
Participating Provider	Participating providers agree to accept a pre-established approved amount as payment in full for service. Provider is used as a global term to include all types of providers
Primary Care Provider (PCP)	A provider (usually a physician, physician group practice, or an entity employing or having other arrangements with such physicians, but sometimes also including nurse providers, nurse midwives, or physician assistants) who manages, coordinates, and monitors covered primary care (and sometimes additional services).
Quality Improvement (QI)	Program provides structure and outlines specific activities designed to improve the care, service and health of Molina Medicare Members.
Risk Adjustment	Payment methodology designed to pay appropriate premiums for each Molina Medicare Member. CMS bases its premium payment according to the health status of each Member.
Service Area	The area where a health plan accepts Members. For plans that require participating doctors and hospitals to be used, it is also the area where services are provided. The plan may disenroll Members who move out of the plans service area.
Skilled Nursing Facility (SNF)	A nursing facility with the staff and equipment to give skilled nursing care and/or skilled rehabilitation services and other related health services.
Skilled Nursing Facility Care	This is a level of care that requires the daily involvement of skilled nursing or rehabilitation staff and that, as a practical matter, can't be provided on an outpatient basis.
Special Needs Plan	A special type of plan that provides more focused healthcare for specific groups of people, such as those who have both Medicare and Medicaid, or those who reside in a nursing home.
TTY	A teletypewriter (TTY) is a communication device used by people who are deaf, hard of hearing, or have severe speech impairment. A TTY consists of a keyboard, display screen, and modem. Messages travel over regular telephone lines. People who don't have a TTY can communicate with a TTY user through a message relay center (MRC). An MRC has TTY operators available to send and interpret TTY messages.

Term	Definition
Urgently Needed Services	Care that Members get for a sudden illness or injury that needs medical care right away, but is not life threatening. PCPs generally provide urgently needed care if the member is in a Medicare health plan other than the Original Medicare Plan. If a member is out of the plan's service area for a short time and cannot wait until the return home, the health plan must pay for urgently needed care.
Waste	Healthcare spending that can be eliminated without reducing the quality of care. Quality Waste includes, overuse, underuse, and ineffective use. Inefficiency Waste includes redundancy, delays, and unnecessary process complexity. For example: the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent, however the outcome of poor or inefficient billing methods (e.g., coding) causes unnecessary costs to the Medicaid/Medicare programs.

